# TITLE 9. HEALTH SERVICES

## CHAPTER 31. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM CHILDREN'S HEALTH INSURANCE PROGRAM

***Editor's Note: The Office of the Secretary of State publishes all Chapters on white paper (Supp. 01-3).***

***Editor's Note: Articles 1 through 13, and Article 16 were adopted under an exemption from the Arizona Administrative Procedure Act (A.R.S. Title 41, Chapter 6) pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session. Although exempt from certain provisions of the rulemaking process, AHCCCS submitted a notice of docket opening with the Secretary of State for publication in the Arizona Administrative Register. Exemption from A.R.S. Title 41, Chapter 6 means AHCCCS was not required to submit these rules to the Governor's Regulatory Review Council for review; they did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and they were not required to hold public hearings on these rules. Because this Chapter contains rules that are exempt from the regular rulemaking process, it is printed on blue paper.***

### ARTICLE 1. DEFINITIONS

*Article 1, consisting of Sections R9-31-101 thru R9-31-116, adopted effective October 23, 1998, under an exemption from the Administrative Procedure Act. (Supp. 98-4).*

Section
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### ARTICLE 2. SCOPE OF SERVICES

*Article 2, consisting of Sections R9-31-201 thru R9-31-216, adopted effective October 23, 1998, under an exemption from the Administrative Procedure Act. (Supp. 98-4).*

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R9-31-203. Reserved
R9-31-204. Inpatient General Hospital Services
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R9-31-206. Organ and Tissue Transplantation Services
R9-31-207. Dental Services
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R9-31-209. Pharmaceutical Services
R9-31-210. Emergency Medical Services
R9-31-211. Transportation Services
R9-31-212. Medical Supplies, Durable Medical Equipment, and Orthotic and Prosthetic Devices
R9-31-213. Health Risk Assessment and Screening Services
R9-31-214. Reserved
R9-31-215. Other Medical Professional Services
R9-31-216. NF, Alternative HCBS Setting, or HCBS

### ARTICLE 3. ELIGIBILITY AND ENROLLMENT

*Article 3, consisting of Sections R9-31-301 thru R9-31-310, adopted effective October 23, 1998, under an exemption from the Arizona Administrative Procedure Act. (Supp. 98-4).*

Section
R9-31-301. General Requirements
R9-31-302. Applications
R9-31-303. Eligibility Criteria
R9-31-304. Income Eligibility
R9-31-305. Verification
R9-31-306. Enrollment
R9-31-307. Guaranteed Enrollment
R9-31-308. Changes and Redeterminations
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R9-31-310. Notice Requirements

### ARTICLE 4. REPEALED

*Article 4, consisting of Sections R9-31-401 through R9-31-407, repealed by final rulemaking at 8 A.A.R. 452, effective January 10, 2002 (Supp. 02-1).*

*Article 4, consisting of Sections R9-31-401 thru R9-31-407, adopted effective October 23, 1998, under an exemption from the Administrative Procedure Act. (Supp. 98-4).*

Section
R9-31-401. Repealed
R9-31-402. Repealed
R9-31-403. Repealed
R9-31-404. Repealed
R9-31-405. Repealed
R9-31-406. Repealed
R9-31-407. Repealed

### ARTICLE 5. GENERAL PROVISIONS AND STANDARDS

*Article 5, consisting of Sections R9-31-501 thru R9-31-529, adopted effective October 23, 1998, under an exemption from the Administrative Procedure Act. (Supp. 98-4).*

Section
R9-31-501. General Provisions
R9-31-502. Availability and Accessibility of Service
R9-31-503. Repealed
R9-31-504. Marketing; Prohibition against Inducements; Misrepresentations; Discrimination; Sanctions
R9-31-505. Approval of Advertisements and Marketing Materials
R9-31-506. Reserved
R9-31-507. Member Record
R9-31-508. Limitation of Benefit Coverage for Illness or Injury due to Catastrophe
R9-31-509. Transition and Coordination of Member Care
R9-31-510. Transfer of Members
R9-31-511. Fraud or Abuse
R9-31-512. Release of Safeguarded Information by the Administration and Contractors
R9-31-513. Discrimination Prohibition
R9-31-514. Equal Opportunity
R9-31-515. Reserved

**ARTICLE 6. RFP AND CONTRACT PROCESS**

*Article 6, consisting of Section R9-31-601, adopted effective October 23, 1998, under an exemption from the Administrative Procedure Act. (Supp. 98-4).*



**ARTICLE 7. STANDARDS FOR PAYMENTS**

*Article 7, consisting of Sections R9-31-701 thru R9-31-717, adopted effective October 23, 1998, under an exemption from the Administrative Procedure Act. (Supp. 98-4).*



**ARTICLE 8. REPEALED**

*Article 8, consisting of Sections R9-31-801 through R9-31-803 and Exhibit A, repealed by final rulemaking at 10 A.A.R. 822, effective April 3, 2004. The subject matter of Article 8 is now in 9 A.A.C. 34 (Supp. 04-1).*

*Article 8, consisting of Sections R9-31-801 thru R9-31-804, adopted effective October 23, 1998, under an exemption from the Administrative Procedure Act. (Supp. 98-4).*



**ARTICLE 9. QUALITY CONTROL**

*Article 9, consisting of Section R9-31-901, adopted effective October 23, 1998, under an exemption from the Administrative Procedure Act. (Supp. 98-4).*



**ARTICLE 10. FIRST- AND THIRD-PARTY LIABILITY AND RECOVERIES**

*Article 10, consisting of Sections R9-31-1001 and R9-31-1002, adopted effective October 23, 1998, under an exemption from the Administrative Procedure Act. (Supp. 98-4).*



**ARTICLE 11. CIVIL MONETARY PENALTIES AND ASSESSMENTS**

*Article 11, consisting of Sections R9-31-1101 thru R9-31-1104, adopted effective October 23, 1998, under an exemption from the Administrative Procedure Act. (Supp. 98-4).*



**ARTICLE 12. BEHAVIORAL HEALTH SERVICES**

*Article 12, consisting of Sections R9-31-1201 through R9-31-1207, repealed; new Article 12, consisting of Sections R9-31-1201 through R9-31-1208, adopted by exempt rulemaking at 6 A.A.R. 282, effective December 16, 1999 (Supp. 99-4).*

*Article 12, consisting of Sections R9-31-1201 through R9-31-1207, adopted effective October 23, 1998, under an exemption from the Administrative Procedure Act. (Supp. 98-4).*

## ARTICLE 13. REPEALED

*Article 13, consisting of Sections R9-31-1301 through R9-31-1309, repealed by final rulemaking at 10 A.A.R. 822, effective April 3, 2004. The subject matter of Article 13 is now in 9 A.A.C. 34 (Supp. 04-1).*

*Article 13, consisting of Sections R9-31-1301 thru R9-31-1309, adopted effective October 23, 1998, under an exemption from the Administrative Procedure Act. (Supp. 98-4).*

Section
R9-31-1301. Repealed
R9-31-1302. Repealed
R9-31-1303. Repealed
R9-31-1304. Repealed
R9-31-1305. Repealed
R9-31-1306. Repealed
R9-31-1307. Repealed
R9-31-1308. Repealed
R9-31-1309. Repealed

## ARTICLE 14. PREMIUMS

*Article 14, consisting of Sections R9-31-1401 through R9-31-1406, adopted effective September 10, 1999, under an exemption from the Administrative Procedure Act (Supp. 99-3).*

Section
R9-31-1401. Purpose
R9-31-1402. Premium Amount for a Member who is a Child Determined Eligible Under Article 3 of This Chapter
R9-31-1403. Repealed
R9-31-1404. Hardship Exemption for a Member who is a Child Determined Eligible Under Article 3 of This Chapter
R9-31-1405. Repealed
R9-31-1406. Repealed
R9-31-1407. Repealed
R9-31-1408. Premium Amount for a Member who is a Parent Determined Eligible Under Article 17 of This Chapter
R9-31-1409. Payment Due Date
R9-31-1410. Payment Received Date
R9-31-1411. Late Payment
R9-31-1412. Payment Type
R9-31-1413. Returned Check
R9-31-1414. Payment in Advance
R9-31-1415. Payment Reimbursement
R9-31-1416. Allocation of Payment for an Eligible Member
R9-31-1417. Premium Change
R9-31-1418. Discontinuance for Failure to Pay Premium
R9-31-1419. Premium During the Grievance and Request for Hearing Process

## ARTICLE 15. RESERVED

## ARTICLE 16. SERVICES FOR NATIVE AMERICANS

*Article 16, consisting of Sections R9-31-1601 thru R9-31-1625, adopted effective October 23, 1998, under an exemption from the Administrative Procedure Act. (Supp. 98-4).*

Section
R9-31-1601. General Requirements
R9-31-1602. General Requirements for Scope of Services
R9-31-1603. Inpatient General Hospital Services
R9-31-1604. Physician and Primary Care Physician and Practitioner Services
R9-31-1605. Organ and Tissue Transplantation Services
R9-31-1606. Dental Services
R9-31-1607. Laboratory, Radiology, and Medical Imaging Services
R9-31-1608. Pharmaceutical Services
R9-31-1609. Emergency Services
R9-31-1610. Transportation Services
R9-31-1611. Medical Supplies, Durable Medical Equipment, and Orthotic and Prosthetic Devices
R9-31-1612. Health Risk Assessment and Screening Services
R9-31-1613. Other Medical Professional Services
R9-31-1614. NF, Alternative HCBS Setting, or HCBS
R9-31-1615. Eligibility and Enrollment
R9-31-1616. Standards for Payments
R9-31-1617. Prior Authorization
R9-31-1618. Claims Submission to the Administration
R9-31-1619. Hospital Claims Review
R9-31-1620. Prohibitions Against Charges to Members
R9-31-1621. Transfer of Payments
R9-31-1622. The Administration's Liability to Hospitals for the Provision of Emergency and Subsequent Care
R9-31-1623. Repealed
R9-31-1624. Specialty Contracts
R9-31-1625. Behavioral Health Services

## ARTICLE 17. ELIGIBILITY AND ENROLLMENT FOR A PARENT

*Article 17, consisting of Sections R9-31-1701 through R9-31-1724, made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4).*

Section
R9-31-1701. General
R9-31-1702. Application
R9-31-1703. Parent Eligibility Criteria
R9-31-1704. Income
R9-31-1705. Citizenship
R9-31-1706. Residency
R9-31-1707. Social Security Number (SSN)
R9-31-1708. Age
R9-31-1709. Ineligibility for Title XIX
R9-31-1710. Institutionalized Person
R9-31-1711. Other Health Coverage
R9-31-1712. State Health Benefits
R9-31-1713. Prior Health Insurance Coverage
R9-31-1714. Premium
R9-31-1715. Non-payment of Premium
R9-31-1716. Verification
R9-31-1717. Assignment of Rights
R9-31-1718. Approval and Effective Date of Eligibility
R9-31-1719. Enrollment
R9-31-1720. Change and Redetermination
R9-31-1721. Denial of Eligibility
R9-31-1722. Discontinuance of Eligibility
R9-31-1723. Newborn Eligibility
R9-31-1724. Grievance and Request for Hearing Process

## ARTICLE 1. DEFINITIONS

**R9-31-101. Location of Definitions**

**A.** Location of definitions. Definitions applicable to 9 A.A.C. 31 are found in the following.

| Definition | Section or Citation |
|---|---|
| "ADHS" | R9-31-112 |
| "Administration" | A.R.S. § 36-2901 |
| "Adverse action" | R9-31-108 |
| "Aggregate" | R9-22-107 |
| "AHCCCS" | R9-31-101 |
| "AHCCCS registered provider" | R9-22-101 |
| "Ambulance" | R9-22-102 |

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| "Ancillary department" | R9-22-107 |
| "Applicant" | R9-31-101 |
| "Application" | R9-31-101 |
| "Behavior management service" | R9-31-112 |
| "Behavioral health professional" | R9-31-112 |
| "Behavioral health evaluation" | R9-31-112 |
| "Behavioral health medical practitioner" | R9-31-112 |
| "Behavioral health service" | R9-31-112 |
| "Behavioral health technician" | R9-20-101 |
| "Billed charges" | R9-22-107 |
| "Board-eligible for psychiatry" | R9-31-112 |
| "Capital costs" | R9-22-107 |
| "Certified nurse practitioner" | R9-31-102 |
| "Certified psychiatric nurse practitioner" | R9-31-112 |
| "Child" | 42 U.S.C. 1397jj |
| "Chronically ill" | A.R.S. § 36-2983 |
| "Clean claim" | A.R.S. § 36-2904 |
| "Clinical supervision" | R9-31-112 |
| "CMDP" | R9-31-103 |
| "Continuous stay" | R9-22-101 |
| "Contract" | R9-22-101 |
| "Contractor" | A.R.S. § 36-2901 |
| "Contract year" | R9-31-101 |
| "Copayment" | R9-22-107 |
| "Cost avoidance" | R9-31-110 |
| "Cost-to-charge ratio" | R9-22-107 |
| "Covered charges" | R9-31-107 |
| "Covered services" | R9-22-102 |
| "CPT" | R9-22-107 |
| "CRS" | R9-31-103 |
| "Date of eligibility posting" | R9-22-107 |
| "Day" | R9-22-101 |
| "De novo hearing" | 42 CFR 431.201 |
| "Dentures" | R9-22-102 |
| "DES" | R9-31-103 |
| "Determination" | R9-31-103 |
| "Diagnostic services" | R9-22-102 |
| "Director" | A.R.S. § 36-2981 |
| "DME" | R9-22-102 |
| "DRI inflation factor" | R9-22-107 |
| "Emergency medical condition" | 42 U.S.C. 1396b(v) |
| "Emergency medical services" | R9-22-102 |
| "Encounter" | R9-22-107 |
| "Enrollment" | R9-31-103 |
| "Experimental services" | R9-22-101 |
| "Facility" | R9-22-101 |
| "Factor" | R9-22-101 |
| "First-party liability" | R9-22-110 |
| "FPL" | A.R.S. § 36-2981 |
| "Grievance" | R9-22-108 |
| "Group Health Plan" | 42 U.S.C. 1397jj |
| "GSA" | R9-22-101 |
| "Head of Household" | R9-31-103 |
| "Health care practitioner" | R9-31-112 |
| "Hearing" | R9-22-108 |
| "Hearing aid" | R9-22-102 |
| "Home health services" | R9-22-102 |
| "Hospital" | R9-22-101 |
| "Household income" | R9-31-103 |
| "ICU" | R9-22-107 |
| "IGA" | R9-31-116 |
| "IHS" | R9-31-116 |
| "IHS" or "Tribal Facility Provider" | R9-31-116 |
| "Information" | R9-31-103 |
| "IMD" | 42 CFR 435.1009 and R9-22-112 |
| "Inmate of a public institution" | 42 CFR 435.1009 |
| "Inpatient hospital services" | R9-31-101 |
| "License" or "licensure" | R9-22-101 |
| "Medical record" | R9-22-101 |
| "Medical review" | R9-31-107 |
| "Medical services" | R9-22-101 |
| "Medical supplies" | R9-22-101 |
| "Member" | A.R.S. § 36-2981 |
| "Mental disorder" | A.R.S. § 36-501 |
| "Native American" | R9-31-101 |
| "New hospital" | R9-22-107 |
| "NF" or "nursing facility" | 42 U.S.C. 1396r(a) |
| "NICU" | R9-22-107 |
| "Noncontracting provider" | A.R.S. § 36-2981 |
| "Occupational therapy" | R9-22-102 |
| "Offeror" | R9-31-106 |
| "Operating costs" | R9-22-107 |
| "Outlier" | R9-31-107 |
| "Outpatient hospital service" | R9-22-107 |
| "Ownership change" | R9-22-107 |
| "Partial care" | R9-31-112 |
| "Peer group" | R9-22-107 |
| "Pharmaceutical service" | R9-22-102 |
| "Physical therapy" | R9-22-102 |
| "Physician" | A.R.S. § 36-2981 |
| "Post stabilization care services" | 42 CFR 438.113 |
| "Practitioner" | R9-22-102 |
| "Pre-existing condition" | R9-31-105 |
| "Prepaid capitated" | A.R.S. § 36-2981 |
| "Prescription" | R9-22-102 |
| "Primary care physician" | A.R.S. § 36-2981 |
| "Primary care practitioner" | A.R.S. § 36-2981 |
| "Primary care provider (PCP)" | R9-22-102 |
| "Primary care provider services" | R9-22-102 |
| "Prior authorization" | R9-22-102 |
| "Private duty nursing services" | R9-22-102 |
| "Program" | A.R.S. § 36-2981 |
| "Proposal" | R9-31-106 |
| "Prospective rates" | R9-22-107 |
| "Provider" | A.R.S. § 36-2931 |
| "PSP" or "Premium Sharing Program" | R9-31-103 |
| "Psychiatrist" | R9-31-112 |
| "Psychologist" | R9-31-112 |
| "Psychosocial rehabilitation" | R9-31-112 |
| "Qualified alien" | A.R.S. § 36-2903.03 |
| "Qualifying plan" | A.R.S. § 36-2981 |
| "Quality management" | R9-22-105 |
| "Radiology services" | R9-22-102 |
| "RBHA" | R9-31-112 |
| "Rebasing" | R9-22-107 |
| "Redetermination" | R9-31-103 |
| "Referral" | R9-22-101 |
| "Rehabilitation services" | R9-22-102 |
| "Reinsurance" | R9-22-107 |
| "Remittance advice" | R9-22-107 |
| "RFP" | R9-31-106 |
| "Respiratory therapy" | R9-22-102 |
| "Respondent" | R9-22-108 |
| "Scope of services" | R9-22-102 |
| "SDAD" | R9-22-107 |
| "Seriously ill" | R9-31-101 |
| "Service location" | R9-22-101 |
| "Service site" | R9-22-101 |
| "SMI" or "Seriously mentally ill" | A.R.S. § 36-550 |
| "Specialist" | R9-22-102 |
| "Speech therapy" | R9-22-102 |
| "Spouse" | R9-31-103 |

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| "SSI-MAO" | R9-31-103 |
| "Stabilize" | 42 U.S.C. 1395dd |
| "Standard of care" | R9-22-101 |
| "Sterilization" | R9-22-102 |
| "Subcontract" | R9-22-101 |
| "Subcontractor" | R9-31-101 |
| "Third-party" | R9-22-110 |
| "Third-party liability" | R9-22-110 |
| "Tier" | R9-22-107 |
| "Tiered per diem" | R9-31-107 |
| "TRBHA" | R9-31-116 |
| "Tribal facility" | A.R.S. § 36-2981 |
| "Utilization management" | R9-22-105 |

**B.** General definitions. The words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

"AHCCCS" means the Arizona Health Care Cost Containment System, which is composed of the Administration, contractors, and other arrangements through which health care services are provided to a member.

"Applicant" means a person who submits, or whose representative submits, a written, signed, and dated application for Title XXI benefits.

"Application" means an official request for Title XXI medical coverage made under this Chapter.

"Contract year" means the period beginning on October 1 and continuing until September 30 of the following year.

"Inpatient hospital services" means medically necessary services that require an inpatient stay in an acute care hospital. Inpatient hospital services are provided by or under the direction of a physician or other health care practitioner upon referral from a member's primary care provider.

"Native American" means Indian as specified in 42 CFR 36.1.

"Seriously ill" means a medical or psychiatric condition manifesting itself by acute symptoms that left untreated may result in:

Death,
Disability,
Disfigurement, or
Dysfunction.

"Subcontractor" means a person, agency, or organization that enters into an agreement with a contractor or subcontractor.

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Amended by exempt rulemaking at 6 A.A.R. 282, effective December 16, 1999 (Supp. 99-4). Amended by exempt rulemaking at 6 A.A.R. 3205, effective August 4, 2000 (Supp. 00-3). Amended by exempt rulemaking at 7 A.A.R. 4740, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4). Amended by final rulemaking at 8 A.A.R. 2365, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 8 A.A.R. 3350, effective July 15, 2002 (Supp. 02-3).

**R9-31-102. Scope of Services Related Definitions**
Definitions. The words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning: "Certified nurse practitioner" means a registered nurse practitioner as certified by the Arizona Board of Nursing according to A.R.S. Title 32, Chapter 15.

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

**R9-31-103. Eligibility and Enrollment Related Definitions**
Definitions. The words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

"CMDP" means Comprehensive Medical and Dental Program.

"CRS" means Children's Rehabilitative Services.

"DES" means the Department of Economic Security.

"Determination" means the process by which an applicant is approved or denied for coverage.

"Enrollment" means the process by which a person is determined eligible for and enrolled in the program.

"Head of household" means the household member who assumes the responsibility for providing eligibility information for the household unit.

"Household income" means the total gross amount of all money received by or directly deposited into a financial account of a member of the household income group as defined in R9-31-304.

"Information" means the knowledge received or communicated in written or oral form regarding a circumstance or proof of a circumstance.

"PSP" means Premium Sharing Program, established according to A.R.S. § 36-2923.01.

"Redetermination" means the periodic review of a member's continued Title XXI eligibility.

"Spouse" means the husband or wife of a Title XXI applicant or household member, who has entered into a contract of marriage, recognized as valid by Arizona.

"SSI-MAO" means Supplemental Security Income-Medical Assistance Only.

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4).

**R9-31-104. Reserved**

**R9-31-105. General Provisions and Standards**
Definitions. The words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning: "Pre-existing condition" means an illness or injury that is diagnosed or treated within a six-month period preceding the effective date of coverage.

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

**R9-31-106. Request for Proposal (RFP) Related Definitions**

Definitions. The words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

1. "Offeror" means a person or other entity that submits a proposal to the Administration in response to an RFP.
2. "Proposal" means all documents including best and final offers submitted by an offeror in response to a Request for Proposals by the Administration.
3. "RFP" means Request for Proposals including all documents, whether attached or incorporated by reference, which are used by the Administration for soliciting a proposal according to this Article.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3).

**R9-31-107. Standards for Payments Related Definitions**

Definitions. The words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

"Covered charges" means billed charges that represent medically necessary, reasonable, and customary items of expense for Title XXI covered services that meet medical review criteria of the Administration or contractor.

"Medical review" means a review involving clinical judgment of a claim or a request for a service before or after it is paid or rendered to ensure that services provided to a member are medically necessary and covered services and that required authorizations are obtained by the provider. The criteria for medical review are established by the contractor based on medical practice standards that are updated periodically to reflect changes in medical care.

"Outlier" means a hospital claim or encounter in which the Title XXI inpatient hospital days of care have operating costs per day that meet the criteria described in A.A.C. R9-22-712.

"Tiered per diem" means a payment structure in which payment is made on a per-day basis depending upon the tier into which the Title XXI inpatient hospital day of care is assigned.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 3350, effective July 15, 2002 (Supp. 02-3).

**R9-31-108. Repealed**

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 6 A.A.R. 3205, effective August 4, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 822, effective April 3, 2004 (Supp. 04-1).

**R9-31-109. Reserved**

**R9-31-110. Repealed**

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed by final rulemaking at 10 A.A.R. 1152, effective May 1, 2004 (Supp. 04-1).

**R9-31-111. Reserved**

**R9-31-112. Covered Behavioral Health Services Related Definitions**

Definitions. The words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

"ADHS" means the Arizona Department of Health Services, the agency mandated to serve the public health needs of all Arizona residents.

"Behavior management service" means those services that assist the member in carrying out daily living tasks and other activities essential for living in the community.

"Behavioral health evaluation" means the assessment of a member's medical, psychological, psychiatric, or social condition to determine if a behavioral health disorder exists and, if so, to establish a treatment plan for all medically necessary services.

"Behavioral health medical practitioner" means a health care practitioner with at least one year of full-time behavioral health work experience.

"Behavioral health professional" defined in 9 A.A.C. 20.

"Behavioral health service" means those services provided for the evaluation and diagnosis of a mental health or substance abuse condition, and the planned care, treatment, and rehabilitation of the member.

"Behavioral health technician" defined in 9 A.A.C. 20.

"Board-eligible for psychiatry" means completion of an accredited psychiatry residency program approved by the American College of Graduate Medical Education, or the American Osteopathic Association defined in 9 A.A.C. 22, Article 1.

"Certified psychiatric nurse practitioner" defined in 9 A.A.C. 22, Article 1.

"Clinical supervision" specified in A.A.C. 22, Article 1.

"De novo hearing" defined in 42 CFR 431.201.

"Health care practitioner" means a:

Physician;
Physician assistant;
Nurse practitioner; or
Other individual licensed and authorized by law to dispense and prescribe medication and devices, as defined in A.R.S. § 32-1901.

"IMD" defined in 9 A.A.C. 22, Article 1.

"Mental disorder" defined in A.R.S. § 36-501.

"Partial Care" defined in 9 A.A.C. 22, Article 1.

"Psychiatrist" specified in A.R.S. §§ 32-1401 or 32-1800 and 36-501.

"Psychologist" specified in A.R.S. §§ 32-2061 and 36-501.

"Psychosocial rehabilitation" defined in 9 A.A.C. 22, Article 1.

"RBHA" means the Regional Behavioral Health Authority defined in A.R.S. § 36-3401.

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 6 A.A.R. 282, effective December 16, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4740, effective October 1, 2001 (Supp. 01-3).

**R9-31-113. Repealed**

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed by exempt rulemaking at 6 A.A.R. 3205, effective August 4, 2000 (Supp. 00-3).

**R9-31-114. Reserved**

**R9-31-115. Reserved**

**R9-31-116. Services for Native Americans Related Definitions**
Definitions. The words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

"IGA" means intergovernmental agreement.

"IHS" means Indian Health Service.

"IHS or Tribal Facility Provider" means a person who is authorized by the IHS or Tribal Facility to provide covered services to members and:

Is an AHCCCS registered provider, and

Is certified by the IHS or Tribal Facility as meeting all applicable federal and state requirements.

"TRBHA" means a Tribal Regional Behavioral Health Authority operated by a tribal government through an IGA with ADHS for the provision of behavioral health services to a Native American member residing on reservation.

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 3350, effective July 15, 2002 (Supp. 02-3).

## ARTICLE 2. SCOPE OF SERVICES

**R9-31-201. General Requirements**

**A.** The Administration shall administer the Children's Health Insurance Program under A.R.S. § 36-2982.

**B.** Scope of Services for fee for service members is under Article 16 of this Chapter.

**C.** A contractor or RBHA shall provide behavioral health services under 9 A.A.C. 31, Article 12 and Article 16.

**D.** In addition to requirements and limitations specified in this Chapter, the following general requirements apply:
1. Only medically necessary, cost effective, and federally and state reimbursable services are covered services;
2. The Administration or a contractor may waive the covered services referral requirements required by this Article;
3. Except as authorized by a contractor, a primary care provider, practitioner, or dentist shall provide or direct the member's covered services. Delegation of the provision of care to a practitioner shall not diminish the role or responsibility of the primary care provider;
4. A contractor shall offer a female member direct access to preventive and routine services from gynecology providers within the contractor's network without a referral from a primary care provider;
5. A member may receive behavioral health evaluation services without a referral from a primary care provider. Behavioral health treatment services are provided only under referral from and in consultation with the primary care provider, or upon authorization by the contractor or its designee;
6. A member may receive a treatment that is considered the standard of care, or that is approved by AHCCCS Chief Medical Officer after appropriate consultative input from providers who are considered experts in the field by the professional medical community;
7. An AHCCCS registered provider shall provide covered services within the provider's scope of practice;
8. In addition to the specific exclusions and limitations otherwise specified under this Article the following are not covered:
   a. A service that the Chief Medical Officer determines to be experimental or provided primarily for the purpose of research;
   b. Services or items furnished gratuitously;
   c. Personal care items; and
9. Medical or behavioral health services are not covered if provided to:
   a. An inmate of a public institution,
   b. A person who is a resident of an institution for the treatment of tuberculosis, or
   c. A person who is in an IMD at the time of application, unless provided under Article 12 of this Chapter.

**E.** The contractor may deny payment of non-emergency services if prior authorization is not obtained under this Article and Article 7 of this Chapter. The provider shall submit documentation of diagnosis and treatment for reimbursement of services that require prior authorization.

**F.** Prior authorization is not required for services necessary to evaluate and stabilize an emergency medical condition. Diagnostic and treatment procedures for a condition that is unrelated to the emergency medical condition require prior authorization by the contractor.

**G.** Under A.R.S. § 36-2989, a member shall receive covered services outside the contractor service area only if one of the following apply:
1. A member is referred by a primary care provider for medical specialty care out of the contractor's area. If a member is referred out of a contractor's service area to receive an authorized medically necessary service, a contractor shall also provide all other medically necessary covered services for a member;
2. There is a net savings in service delivery costs as a result of going outside the service area that does not require undue travel time or hardship for a member or the member's family;
3. The contractor authorizes placement in a nursing facility located out of the contractor's service area; or

**H.** If a member is traveling or temporarily residing out of the member's contractor service area, covered services are restricted to emergency care services, unless otherwise authorized by the contractor.

**I.** A contractor shall provide at a minimum, directly or through subcontracts, the covered services specified in this Chapter and in contract.

**J.** If a member requests the provision of a service that is not covered or not authorized by a contractor, an AHCCCS-registered service provider may render the service and request reimbursement from the member if:
1. The provider prepares, and provides the member with, a document that lists the requested services and the estimated cost of each service; and
2. The member signs a document before the provision of services indicating that the member understands the services and accepts the responsibility for payment.

**K.** The restrictions, limitations, and exclusions in this Article do not apply to a contractor if the contractor elects to provide noncovered services:
1. The Administration shall not consider the costs of providing a noncovered service to a member in the development or negotiation of a capitation rate;
2. A contractor shall pay noncovered services from administrative revenue or other contractor funds that are unrelated to the provision of services under this Chapter.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Amended by exempt rulemaking at 7 A.A.R. 4740, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 8 A.A.R. 2365, effective May 9, 2002 (Supp. 02-2).

**R9-31-202. Reserved**

**R9-31-203. Reserved**

**R9-31-204. Inpatient General Hospital Services**

A contractor, fee-for-service provider, or noncontracting provider shall render inpatient general hospital services including:
1. Hospital accommodations and appropriate staffing, supplies, equipment, and services for:
   a. Maternity care, including labor, delivery, recovery room, birthing center, and newborn nursery;
   b. Neonatal intensive care unit (NICU);
   c. Intensive care unit (ICU);
   d. Surgery, including surgery room and recovery room;
   e. Nursery and related services;
   f. Routine care; and
   g. Emergency behavioral health services under 9 A.A.C. 31, Article 12.
2. Ancillary services as specified by the Director and included in contract:
   a. Laboratory services;
   b. Radiological and medical imaging services;
   c. Anesthesiology services;
   d. Rehabilitation services;
   e. Pharmaceutical services and prescription drugs;
   f. Respiratory therapy;
   g. Blood and blood derivatives; and
   h. Central supply items, appliances, and equipment not ordinarily furnished to all patients which are customarily reimbursed as ancillary services.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 2365, effective May 9, 2002 (Supp. 02-2).

**R9-31-205. Attending Physician, Practitioner, and Primary Care Provider Services**

**A.** A primary care provider shall provide primary care provider services within the provider's scope of practice under A.R.S. Title 32. A member may receive primary care provider services in an inpatient or outpatient setting including at a minimum:
1. Periodic health examination and assessment,
2. Evaluation and diagnostic workup,
3. Medically necessary treatment,
4. Prescriptions for medication and medically necessary supplies or equipment,
5. Referral to a specialist or other health care professional if medically necessary as specified in A.R.S. § 36-2989,
6. Patient education,
7. Home visits if medically necessary,
8. Covered immunizations, and
9. Covered preventive health services.

**B.** As specified in A.R.S. § 36-2989, a second opinion procedure may be required to determine coverage for surgery. Under this procedure, documentation must be provided by at least two physicians as to the need for the proposed surgery for the member.

**C.** The following limitations and exclusions apply to physician and practitioner services and primary care provider services:
1. Specialty care and other services provided to a member upon referral from a primary care provider are limited to the services or conditions for which the referral is made, or for which authorization is given by the contractor;
2. A member's physical examination is not a covered service if the physical examination is to obtain one or more of the following:
   a. Qualification for insurance,
   b. Pre-employment physical evaluation,
   c. Qualification for sports or physical exercise activities,
   d. Pilot's examination (Federal Aviation Administration),
   e. Disability certification to establish any kind of periodic payments,
   f. Evaluation to establish third-party liabilities, or
   g. Physical ability to perform functions that have no relationship to primary objectives of the services listed in subsection (A).
3. The following services are excluded from AHCCCS coverage:
   a. Infertility services, reversal of surgically induced infertility (sterilization), and gender reassignment surgery;
   b. Pregnancy termination counseling services;
   c. A pregnancy termination, unless authorized under federal law;
   d. A service or item furnished solely for cosmetic purposes;
   e. A hysterectomy, unless determined to be medically necessary; and
   f. Licensed midwife services for prenatal care and home birth.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended

by final rulemaking at 8 A.A.R. 2365, effective May 9, 2002 (Supp. 02-2).

**R9-31-206. Organ and Tissue Transplantation Services**

The following organ and tissue transplantation services shall be covered for a member as specified in A.R.S. § 36-2989 if prior authorized and coordinated with a member's contractor:

1. Kidney transplantation;
2. Simultaneous Kidney/Pancreas transplant;
3. Cornea transplantation;
4. Heart transplantation;
5. Liver transplantation;
6. Autologous and allogeneic bone marrow transplantation;
7. Lung transplantation;
8. Heart-lung transplantation;
9. Other organ transplantation if the transplantation is required by federal law and if other statutory criteria are met; and
10. Immunosuppressant medications, chemotherapy, and other related services.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

**R9-31-207. Dental Services**

Medically necessary dental services are provided for children under age 19 under A.R.S. § 36-2989 and R9-22-213.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 2365, effective May 9, 2002 (Supp. 02-2).

**R9-31-208. Laboratory, Radiology, and Medical Imaging Services**

An AHCCCS-registered provider shall provide laboratory, radiology, and medical imaging services for children under age 19, under A.R.S. § 36-2989 and R9-22-208.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 2365, effective May 9, 2002 (Supp. 02-2).

**R9-31-209. Pharmaceutical Services**

Pharmaceutical services are provided for children under age 19 under R9-22-209.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 2365, effective May 9, 2002 (Supp. 02-2).

**R9-31-210. Emergency Medical Services**

**A.** Emergency medical services shall be provided based on the prudent layperson standard to a member by licensed providers registered with AHCCCS to provide services under A.R.S. § 36-2989.

**B.** The provider of emergency services shall verify eligibility and enrollment status through the Administration to determine the need for notification to a contractor or a RBHA for a member and to determine the party responsible for payment of services rendered.

**C.** Access to an emergency room and emergency medical services shall be available 24 hours per day, seven days per week in each contractor's service area. The use of examining or treatment rooms shall be available when required by a physician or practitioner for the provision of emergency services.

**D.** Behavioral Health Evaluation provided by a psychiatrist or psychologist shall be covered as an emergency service, so long as it meets the requirements of 9 A.A.C. 31, Article 12.

**E.** Emergency services do not require prior authorization but providers shall comply with the following notification requirements:

1. Providers and noncontracting providers furnishing emergency services to a member shall notify the member's contractor within 12 hours of the time the member presents for services;
2. If a member's medical condition is determined not to be an emergency medical condition under Article 1 of this Chapter, the provider shall notify the member's contractor before initiation of treatment and follow the prior authorization requirements and protocol of the contractor regarding treatment of the member's nonemergent condition. Failure to provide timely notice or comply with prior authorization requirements of the contractor constitutes cause for denial of payment.

**F.** A provider and a noncontracting provider shall request authorization from a contractor for post stabilization services. A contractor shall pay for the post stabilization services if:

1. The service is pre-approved by a contractor, or
2. A contractor does not respond to an authorization request within the time-frame under 42 CFR 438.114.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 7 A.A.R. 4740, effective October 1, 2001 (Supp. 01-3).

**R9-31-211. Transportation Services**

The Administration shall provide transportation services under A.A.C. R9-22-211.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4).

**R9-31-212. Medical Supplies, Durable Medical Equipment, and Orthotic and Prosthetic Devices**

**A.** As specified in A.R.S. § 36-2989, medical supplies, DME, and orthotic and prosthetic devices are covered services if provided in compliance with requirements of this Chapter and:

1. Prescribed by the member's primary care provider, practitioner, or dentist;
2. Prescribed by a specialist upon referral from the primary care provider, practitioner, or dentist; and
3. Authorized by the contractor or the contractor's designee.

**B.** Covered medical supplies are consumable items that are disposable and are essential to a member's health.

**C.** Covered DME is any item, appliance, or piece of equipment that is:

1. Designed for a medical purpose,
2. To withstand wear,
3. Generally reusable by others, and
4. Purchased or rented for a member.

**D.** Covered prosthetic and orthotic devices are only those items that are essential for the habilitation or rehabilitation of a member.

**E.** The following limitations on coverage include:
1. DME is furnished on a rental or purchase basis, whichever is less expensive. The total expense of renting the DME does not exceed the cost of the DME if purchased;
2. Reasonable repair or adjustment of purchased DME is covered if necessary to make the DME serviceable and if the cost of repair is less than the cost of renting or purchasing another unit;
3. A change in, or addition to, an original order for DME is covered if approved by the member's primary care provider or authorized prescriber, or prior authorized by the contractor for a member, and the change or addition is indicated clearly on the order and initialed by the vendor. No change or addition to the original order for DME shall be made after a claim for services is submitted to a member's contractor, without prior written notification of the change or addition;
4. Reimbursement for rental fees shall terminate:
   a. No later than the end of the month in which the primary care provider or authorized prescriber certifies that the member no longer needs the DME;
   b. If the member is no longer eligible for AHCCCS services; or
   c. If the member is no longer enrolled with a contractor, with the exception of transitions of care as specified by the Administration.
5. Personal incidentals including items for personal cleanliness, body hygiene, and grooming are not covered unless needed to treat a medical condition and:
   a. Prescribed by:
      i. The member's primary care provider or practitioner, or
      ii. A specialist upon referral from the primary care provider or practitioner; and
   b. Authorized as required by the contractor or its designee;
6. First aid supplies are not covered unless they are provided in accordance with a prescription.

**F.** Liability and ownership.
1. Purchased DME provided to a member that is no longer needed may be disposed of in accordance with each contractor's policy.
2. If customized DME is purchased by the contractor for a member, the DME shall remain with the member during times of transition, or upon loss of eligibility.
   a. For purposes of this Section, customized DME refers to DME that has been altered or built to specifications unique to a member's medical needs and that, most likely, cannot be used or reused to meet the needs of another individual.
   b. A member shall return customized DME obtained fraudulently to the Administration or the contractor.

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 2365, effective May 9, 2002 (Supp. 02-2).

**R9-31-213. Health Risk Assessment and Screening Services**

**A.** As authorized by A.R.S. § 36-2989, the following services shall be covered for a member:
1. Screening services, including:
   a. Comprehensive health, behavioral health and developmental histories;
   b. Comprehensive unclothed physical examination;
   c. Appropriate immunizations according to age and health history; and
   d. Health education, including anticipatory guidance.
2. Vision services including:
   a. Diagnosis and treatment for defects in vision,
   b. Eye examinations for the provision of prescriptive lenses, and
   c. Provision of prescriptive lenses.
3. Hearing services, including:
   a. Diagnosis and treatment for defects in hearing,
   b. Testing to determine hearing impairment, and
   c. Provision of hearing aids.

**B.** All providers of services shall meet the following standards:
1. Provide services by or under the direction of, the member's primary care provider or dentist.
2. Perform tests and examinations as specified in contract and under 42 CFR 441, Subpart B, January 29, 1985, which is incorporated by reference and on file with the Office of the Secretary of State and the Administration. This incorporation by reference contains no future editions or amendments.
3. Refer members as necessary for dental diagnosis and treatment, and necessary specialty care.
4. Refer members as necessary for behavioral health evaluation and treatment services as specified in 9 A.A.C. 31, Article 12.

**C.** A contractor shall meet the following additional conditions for members:
1. Provide information to members and their parents or guardians concerning services; and
2. Notify members and their parents or guardians regarding the initiation of screening and subsequent appointments according to the AHCCCS Administration Periodicity Schedule.

**D.** A contractor, primary care provider, attending physician, or practitioner shall refer a member with special health care needs under A.A.C. R9-7-301 to CRS.

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4).

**R9-31-214. Reserved**

**R9-31-215. Other Medical Professional Services**

The following medical professional services are covered services if a member receives these services in an inpatient, outpatient, or office setting as follows:
1. Dialysis;
2. The following family planning services if provided to delay or prevent pregnancy:
   a. Medications,
   b. Supplies,
   c. Devices, and
   d. Surgical procedures.
3. Family planning services are limited to:
   a. Contraceptive counseling, medication, supplies, and associated medical and laboratory examinations, including HIV blood screening as part of a package

of sexually transmitted disease tests provided with a family planning service; and
b. Natural family planning education or referral;
4. Midwifery services provided by a nurse practitioner certified in midwifery;
5. Podiatry services if ordered by a member's primary care provider as specified in A.R.S. § 36-2989;
6. Respiratory therapy;
7. Ambulatory and outpatient surgery facilities services;
8. Home health services in A.R.S. § 36-2989;
9. Private or special duty nursing services if medically necessary and prior authorized;
10. Rehabilitation services including physical therapy, occupational therapy, speech therapy, and audiology provided under this Article;
11. Total parenteral nutrition services, (which are the provision of total caloric needs by intravenous route for individuals with severe pathology of the alimentary tract);
12. Inpatient chemotherapy;
13. Outpatient chemotherapy; and
14. Hospice care under R9-22-213.

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 2365, effective May 9, 2002 (Supp. 02-2).

**R9-31-216. NF, Alternative HCBS Setting, or HCBS**
**A.** Services provided in a NF, including room and board, alternative HCBS setting as defined in R9-28-101, or HCBS as defined in R9-28-101 are covered for a maximum of 90 days per contract year if the member's medical condition would otherwise require hospitalization.
**B.** Except as otherwise provided in 9 A.A.C. 28, the following services are not itemized for separate billing if provided in a NF, alternative HCBS setting, or HCBS:
1. Nursing services including:
a. Administering medication,
b. Tube feedings,
c. Personal care services (assistance with bathing and grooming),
d. Routine testing of vital signs, and
e. Maintenance of catheter.
2. Basic patient care equipment and sickroom supplies, including:
a. First aid supplies such as bandages, tape, ointment, peroxide, alcohol, and over-the-counter remedies;
b. Bathing and grooming supplies;
c. Identification device;
d. Skin lotion;
e. Medication cup;
f. Alcohol wipes, cotton balls, and cotton rolls;
g. Rubber gloves (non-sterile);
h. Laxatives;
i. Bed and accessories;
j. Thermometer;
k. Ice bags;
l. Rubber sheeting;
m. Passive restraints;
n. Glycerin swabs;
o. Facial tissue;
p. Enemas;
q. Heating pad; and
r. Diapers.
3. Dietary services including preparation and administration of special diets, and adaptive tools for eating;
4. Any service that is included in a NF's room and board charge or a service that is required of the NF to meet a federal mandate, state licensure standard, or county certification requirement;
5. Physician visits made solely for the purpose of meeting a state licensure standard or county certification requirement;
6. Physical therapy; and
7. Assistive device or non-customized DME.

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Amended by final rulemaking at 8 A.A.R. 2365, effective May 9, 2002 (Supp. 02-2).

## ARTICLE 3. ELIGIBILITY AND ENROLLMENT

**R9-31-301. General Requirements**
**A.** Administration. The Administration shall administer the program as specified in A.R.S. § 36-2982.
**B.** Operational authority. The Director has full operational authority to adopt rules or to use the appropriate rules for the development and management of an eligibility and enrollment system as specified in A.R.S. § 36-2986.
**C.** Expenditure limit and enrollment
1. Title XXI will accept enrollees subject to the availability of funds. If the Director determines that monies may be insufficient for the program, the Administration shall stop processing applications for the program as specified in A.R.S. § 36-2985.
2. After the Administration has verified that funding is sufficient, it will resume processing applications as specified in A.R.S. § 36-2985.
3. The Administration shall immediately stop processing all applications and shall provide advance notice to a member that the program will terminate under A.R.S. § 36-2985.
4. A child is not entitled to a hearing under Article 8 of this Chapter, if the program is suspended or terminated.

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4).

**R9-31-302. Applications**
**A.** Availability. The provisions in A.A.C. R9-22-1405(B) apply to this Section. The Administration shall make available program applications. Any person may request a program application.
**B.** Submission of applications. An application is completed and submitted to the Administration:
1. In person,
2. By mail,
3. By fax, or
4. By other form approved by the Administration.
**C.** Date of application. The date of application is the date the Administration or its designee receives an application that:
1. Is signed by the person making the application,
2. Includes the name of the person for whom assistance is requested, and

3. Includes the address and telephone number of the person submitting the application.

**D.** Completed application.
1. The provisions in A.A.C. R9-22-1405(E) apply to this Section.
2. The Administration shall consider an application complete when:
   a. All questions are answered,
   b. An enrollment choice is included, and
   c. All necessary verification is provided by an applicant or an applicant's representative.
3. If the application is incomplete, the Administration shall do one or both of the following:
   a. Contact an applicant or an applicant's representative by telephone to obtain the missing information required for an eligibility determination;
   b. Mail a request for additional information to an applicant or an applicant's representative, allowing 10 days from the date of the request to provide the required additional information.

**E.** Eligibility determination processing time.
1. When an application is complete, the Administration shall mail notification to the applicant regarding the eligibility determination no more than 30 days from the date of application except when there is an emergency beyond the Administration's control.
2. An applicant shall provide the Administration with all requested information within 10 days from the date of the written request for the information. If an applicant fails to provide the requested information and fails to request an extension of the 10 day period or the request for extension is denied, the Administration shall deny eligibility.

**F.** Waiting list. If the Administration stops processing an application because the monies are insufficient as specified in R9-31-301(C)(1), the Administration shall place an applicant on a waiting list and notify the applicant. When sufficient funding becomes available, the Administration shall contact an applicant on the waiting list and ask the applicant to submit a new application if the original application is more than 60 days old. The Administration shall fill spaces in the order that an application is received and approved.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4). Amended by final rulemaking at 9 A.A.R. 5150, effective January 3, 2004 (Supp. 03-4).

**R9-31-303. Eligibility Criteria**

Eligibility. To be eligible for the program, an applicant shall meet all the following eligibility requirements:
1. Age. Is less than 19 years of age. A child's coverage shall continue through the month in which a child turns age 19 if the child is otherwise eligible;
2. Citizenship. Is a United States citizen or a qualified alien under A.R.S. § 36-2983;
3. Residency. Is a resident of the state of Arizona under A.R.S. § 36-2983. An Arizona resident is a person who currently lives in Arizona and intends to remain in Arizona indefinitely;
4. Income. Meets the income requirements in R9-31-304;
5. Cost sharing. Pays the cost sharing premium amount when premiums are required as specified in A.R.S. §§ 36-2982 and 36-2903.01;
6. Social security number (SSN). Provides a SSN or applies for a SSN within 30 days after submitting an application.
7. Assignment. Assigns rights to any first- or third-party coverage of medical care as specified in 9 A.A.C. 31, Article 10;
8. Other federal program. Is not eligible for Medicaid or other federally operated or financed health care insurance program, except the Indian Health Service as specified in A.R.S. § 36-2983;
9. Inmate of a public institution. Is not an inmate of a public institution, as specified in A.R.S. § 36-2983;
10. Patient in an institution for mental disease. Is not a patient in an institution for mental disease at the time of application, or at the time of redetermination, as specified in A.R.S. § 36-2983;
11. Other health coverage. Is not covered under:
    a. An employer's group health insurance plan,
    b. Family or individual health insurance, or
    c. Other health insurance;
12. State health benefits. Is not a member of a family that is eligible for health benefits coverage under a state health benefit plan based on a family member's employment with a public agency in the state of Arizona;
13. Prior health insurance coverage. Has not been covered by health insurance during the previous three months unless that health insurance was discontinued due to the involuntary loss of employment or other involuntary reason as specified in A.R.S. § 36-2983. The three months of ineligibility due to previous insurance coverage shall not apply to:
    a. A newborn as defined in R9-31-309;
    b. A Title XIX member as specified in 9 A.A.C. 22, Article 1;
    c. An applicant who is seriously ill under R9-31-101 or chronically ill under A.R.S. § 36-2983;
    d. A member under this Article who loses insurance coverage;
    e. A CRS member; or
    f. A Native American member receiving services from IHS or a Tribal Facility.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4). Amended by exempt rulemaking at 9 A.A.R. 4560, effective October 1, 2003 (Supp. 03-4). Amended by final rulemaking at 9 A.A.R. 5150, effective January 3, 2004 (Supp. 03-4).

**R9-31-304. Income Eligibility**

**A.** Income standard. The combined gross income of the household income group members as specified in subsection (C) shall not exceed the percentage of the appropriate FPL under A.R.S. § 36-2981 for the Title XXI household income group size.

**B.** Calculating monthly income. The Administration shall calculate monthly income under A.A.C. R9-22-1419.01(B) through 1419.04.

**C.** Title XXI household income group.
1. For this Section:

a. "Child" means a person less than 19 years of age or an unborn child.
b. "Parent" means a biological, adoptive, or step parent.

2. The following related persons, when residing together, constitute a Title XXI household income group:
a. A married couple and children of either one or both;
b. An unmarried couple with a common child and at least one other child of either one or both;
c. A married couple when one or both are under age 19 with no child;
d. A single parent and the single parent's child;
e. A child who does not live with a parent; and
f. The following persons, when living with a child:
i. A spouse of the child;
ii. A child of the spouse child;
iii. A child of the child; and
iv. The other parent of a child of the child.

3. A member of the household income group who is absent from a household shall be included in the child's household income group if absent:
a. For 30 days or less,
b. For the purpose of seeking employment or to maintain a job,
c. For serving in the military, or
d. For an educational purpose and the child's parent claims the child as a dependent on the parent's income tax return.

**D.** Income disregards. When determining gross income of the household, the Administration shall disregard the following:
1. Income specified in 20 CFR 416, Appendix to subpart K as of June 6, 1997, which is incorporated by reference and on file with the Office of the Secretary of State and the Administration. This incorporation by reference contains no future editions or amendments;
2. Income paid according to federal law that prohibits the use of the income when determining eligibility for public benefits;
3. Money received as the result of the conversion of an asset;
4. Income tax refunds; and
5. An amount equal to the expenses of producing self-employment income from the gross self-employment income.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4). Amended by final rulemaking at 9 A.A.R. 5150, effective January 3, 2004 (Supp. 03-4).

**R9-31-305. Verification**

Verification. An applicant or a member shall provide the Administration with verification or authorize the release of verification to the Administration of all information necessary to complete the determination of eligibility.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

**R9-31-306. Enrollment**

**A.** Selection choices.
1. Except as provided in subsections (A)(3), (4), and (5), at the time of application, an applicant shall select from the following enrollment choices:
a. A contractor which includes a contractor or a qualifying plan as defined in A.R.S. § 36-2981, or
b. The IHS as specified in A.R.S. § 36-2982. If a member is enrolled with the IHS, a member may elect to receive covered services from a participating Tribal Facility.
2. Except as provided in subsections (A)(3), (4), and (5), coverage shall not begin until a Title XXI enrollment choice is made.
3. The Administration shall enroll a member with CMDP when a member is a foster care child according to A.R.S. § 8-512.
4. When a Title XIX member becomes ineligible for Title XIX and DES determines the member eligible for Title XXI with no break in coverage,
a. The Title XXI member shall remain enrolled with the Title XIX contractor; and
b. The Administration shall send the Title XXI member a notice explaining the member's right to choose as specified in subsection (A)(1).
5. When an applicant applies for Title XIX through DES and DES determines the applicant ineligible for Title XIX but eligible for Title XXI, the Administration shall enroll the applicant for Title XXI as follows:
a. If a Title XIX contractor pre-enrollment choice is pending at the time the Administration receives the Title XXI approval from DES, the Administration may:
i. Enroll member with the Title XIX contractor, and
ii. Notify the member of the member's enrollment and provide the member an opportunity to select an enrollment choice as specified in subsection (A)(1).
b. If there is no pending Title XIX choice at the time the Administration receives the Title XXI approval from DES, the Administration shall pend the Title XXI decision and obtain a choice from the member as specified in subsection (A)(1).

**B.** Effective date of initial enrollment.
1. For an eligibility determination completed by the 25th day of the month, enrollment shall begin on the first day of the month following the determination of eligibility.
2. For an eligibility determination completed after the 25th day of the month, enrollment shall begin on the first day of the second month following the determination of eligibility.

**C.** Enrollment changes.
1. If a member moves from one GSA to another GSA during the period of enrollment, enrollment changes shall occur as follows:
a. If a member's current enrollment choice is available in a member's new GSA, a member shall remain enrolled with the member's current enrollment choice.
b. If a member's current enrollment choice is not available in the new GSA, a member shall:
i. Remain enrolled with the current enrollment choice. The current enrollment choice may limit services to emergency services outside the GSA as specified in R9-31-201.
ii. Select from the enrollment choices provided in R9-31-306(A)(1) that are available in the new GSA. Once a new choice is made, a member shall be enrolled with the new choice effective

with the date the Administration processes the member's enrollment choice. Covered services shall be available on the date of the enrollment change.

2. A member may change a member's enrollment choice:
   a. During a member's annual enrollment choice period,
   b. At any time from:
      i. IHS to a contractor as specified in subsection (A)(1) of this Section; or
      ii. A contractor to IHS.
   c. When a member is no longer a foster care child as specified in subsection (A)(3) of this Section.
3. Except for subsection (C)(2)(c) of this Section, the effective date of the new enrollment choice is the date the Administration processes the enrollment choice. The effective date of the enrollment change from CMDP to a Title XXI choice as specified in subsection (A)(1) of this Section, shall be the first of the following month.

**D.** Annual enrollment choice period. A member shall have the opportunity to change enrollment no later than 12 months following the last time a member made an enrollment choice or had the opportunity to make an enrollment choice.

**E.** Health Insurance Portability and Accountability Act of 1996. As specified in A.R.S. § 36-2982, a Title XXI member who has been disenrolled shall be allowed to use enrollment in the Title XXI program as creditable coverage as defined in A.R.S. § 36-2984.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4).

**R9-31-307. Guaranteed Enrollment**

**A.** Guaranteed Enrollment. A child who is determined eligible for Title XXI shall be guaranteed a one-time, 12-month period of continuous coverage unless a child:
1. Attains age 19,
2. Is no longer a resident of the state,
3. Is an inmate of a public institution,
4. Is determined to have been ineligible at the time of approval,
5. Obtains private or group health coverage,
6. Is adopted and the new household does not meet the qualifications of this program,
7. Is a patient in an institution for mental diseases,
8. Has whereabouts that are unknown, or
9. Has a head of household who:
   a. Does not pay cost sharing premium amount when premiums are required as specified in A.R.S. §§ 36-2982 and 36-2903.01 and as specified in this Chapter,
   b. Voluntarily withdraws from the program, or
   c. Fails to cooperate in meeting the requirements of the program.

**B.** The 12-month guaranteed period shall begin with the month an applicant is initially enrolled.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4). Amended by exempt rulemaking at 9 A.A.R. 4560, effective October 1, 2003 (Supp. 03-4).

**R9-31-308. Changes and Redeterminations**

**A.** Reporting Changes. A member or a member's parent or guardian shall report the following changes to the Administration:
1. Any increase in income that will begin or continue into the following month,
2. Any change of address,
3. The addition or departure of a household member,
4. Any health coverage under private or group health insurance,
5. Employment of a member or a parent with a state agency, and
6. Incarceration of a member.

**B.** Verification. If required verification is needed and requested as a result of a change specified in subsection (A) of this Section to determine the impact on eligibility and is not received within 10 days, the Administration shall send a notice to discontinue eligibility for a member unless a member is within the guaranteed eligibility period as specified in R9-31-307.

**C.** Redeterminations. If no change is reported, the Administration shall initiate redetermination no later than the end of the 12th month after the effective date of eligibility, or the completion of the most recent redetermination decision whichever is later.

**D.** Termination. If the Administration determines that a child no longer meets the eligibility criteria, or a head of household fails to respond or cooperate with the redetermination of eligibility, the Administration shall terminate coverage.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4).

**R9-31-309. Newborn Eligibility**

**A.** Eligibility. A child born to a Title XXI member, is eligible for 12 months of coverage without filing an application under Title XXI provided:
1. The child continues to live with the child's mother during the 12-month period; and
2. One of the events as specified in R9-31-307(A) does not occur.

**B.** Deemed Coverage. A newborn's deemed newborn coverage shall begin effective with a newborn's date of birth and end with the last day of the month in which a newborn turns age 1. Deemed newborn status does not preclude a child from applying for Title XIX and being approved.

**C.** Enrollment choice for a newborn. A newborn shall be enrolled with a mother's enrollment choice as specified in contract.

**D.** Notification of enrollment. The Administration shall notify a mother of a newborn's enrollment and provide a mother an opportunity to select an enrollment choice as specified in R9-31-306(A)(1).

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3).

**R9-31-310. Notice Requirements**

**A.** Applications. Upon completion of a determination of eligibility or ineligibility for any child in the household, the Administration shall issue a written notice to an individual who

initiated the application. This notice shall include a statement of the intended action, an explanation of a person's hearing rights as specified in 9 A.A.C. 31, Article 8, and:

1. If approved, the notice shall contain the name and effective date of eligibility for each approved applicant;
2. If denied, the notice shall contain:
   a. The name of each ineligible applicant,
   b. The effective date of the denial,
   c. The reasons for ineligibility including appropriate income calculations and income standard when the reason for the denial is based on excess income,
   d. The legal authority supporting the reason for ineligibility, and
   e. The resource or reference materials where the legal authority citations are found.

**B.** Terminations.

1. When the Administration proposes a termination of Title XXI eligibility, the Administration shall provide a member with:
   a. Advance notice at least 10 days before the effective date of the adverse action except as provided in subsection (B)(1)(b).
   b. Adequate notice no later than the date of adverse action when a member:
      i. Voluntarily withdraws and indicates an understanding of the results of the action,
      ii. Becomes an inmate of a public institution as specified in R9-31-303(I),
      iii. Dies and the Administration has verification of the death,
      iv. Has whereabouts that are unknown and the Administration's loss of contact is confirmed by returned mail from the post office with no forwarding address, or
      v. Is approved for Title XIX.
2. In addition to the requirements listed in subsection (A)(2), the termination notice shall include an explanation of a member's right to continued Title XXI coverage pending a request for hearing as provided in 9 A.A.C. 31, Article 8 and 14.

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 5 A.A.R. 3670, effective September, 10, 1999 (Supp. 99-3). Amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4).

## ARTICLE 4. REPEALED

**R9-31-401. Repealed**

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Section repealed by final rulemaking at 8 A.A.R. 452, effective January 10, 2002 (Supp. 02-1).

**R9-31-402. Repealed**

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed by final rulemaking at 8 A.A.R. 452, effective January 10, 2002 (Supp. 02-1).

**R9-31-403. Repealed**

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed by final rulemaking at 8 A.A.R. 452, effective January 10, 2002 (Supp. 02-1).

**R9-31-404. Repealed**

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed by final rulemaking at 8 A.A.R. 452, effective January 10, 2002 (Supp. 02-1).

**R9-31-405. Repealed**

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed by final rulemaking at 8 A.A.R. 452, effective January 10, 2002 (Supp. 02-1).

**R9-31-406. Repealed**

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed by final rulemaking at 8 A.A.R. 452, effective January 10, 2002 (Supp. 02-1).

**R9-31-407. Repealed**

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed by final rulemaking at 8 A.A.R. 452, effective January 10, 2002 (Supp. 02-1).

## ARTICLE 5. GENERAL PROVISIONS AND STANDARDS

**R9-31-501. General Provisions**

**A.** As specified in A.R.S. § 36-2986, the Director has full operational authority to adopt rules or to use the appropriate rules adopted for this Article.

**B.** Pre-existing Conditions. Eligibility for the program may not be denied based on a child having a pre-existing medical condition as specified in 42 U.S.C. 1397, August 5, 1997, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.

1. Except as otherwise provided in Article 3 of this Chapter, a contractor shall be responsible for providing the full scope of covered services to each member from the effective date of eligibility until the time of notification of termination, suspension, or transfer of the member's enrollment. This responsibility includes providing treatment for all of a member's pre-existing conditions.
2. A contractor or subcontractor shall not adopt or use any procedure to identify individuals who have an existing or anticipated medical or psychiatric condition in order to discourage or exclude the individuals from enrolling in

the contractor's health plan or encourage the individuals to enroll in another health plan.

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

**R9-31-502. Availability and Accessibility of Service**

**A.** A contractor shall provide adequate numbers of available and accessible:
1. Institutional facilities;
2. Service locations;
3. Service sites; and
4. Professional, allied, and paramedical personnel for the provision of covered services, including all emergency medical services for 24 hours a day, seven days a week.

**B.** A contractor shall minimally provide the following:
1. A ratio of primary care providers to members, as specified in contract.
2. A designated emergency services facility, providing care 24 hours a day, seven days a week, accessible to members in each contracted service area. One or more physicians and one or more nurses shall be on call or on duty at the facility at all times.
3. An emergency services system employing at least one physician, registered nurse, physician's assistant, or nurse practitioner, accessible by telephone 24 hours a day, seven days a week, to members who need information in an emergency, and to providers who need verification of patient membership and treatment authorization.
4. An emergency services call log or database to track the following information:
   a. Member's name,
   b. Address and telephone number,
   c. Date and time of call,
   d. Nature of complaint or problem, and
   e. Instructions given to member.
5. A written procedure for communicating emergency services information to a member's primary care provider, and other appropriate organizational units.
6. An appointment standard as specified in contract for the following:
   a. Emergency appointments,
   b. Urgent care appointments, and
   c. Routine care appointments.
7. Waiting times for members with appointments that do not exceed 45 minutes, except when the provider is unavailable due to an emergency.

**C.** A contractor shall have an affiliation with or subcontract with an organization or individual to provide primary care services. The contractor shall agree to provide services under the primary care provider's guidance and direction.
1. A primary care provider selected by or to whom an enrolled member is assigned shall be responsible for:
   a. Supervising, coordinating, and providing initial and primary care to the member;
   b. Initiating referrals for specialty care;
   c. Maintaining continuity of member care; and
   d. Maintaining an individual medical record for each assigned member.
2. A primary care provider or specialist providing inpatient services to a member shall have staff privileges in a minimum of one general acute care hospital under subcontract with the contractor, within the service area of the contractor.

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3).

**R9-31-503. Repealed**

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Section repealed by final rulemaking at 8 A.A.R. 3350, effective July 15, 2002 (Supp. 02-3).

**R9-31-504. Marketing; Prohibition against Inducements; Misrepresentations; Discrimination; Sanctions**

**A.** A contractor or the any person or entity acting as the contractor's marketing agent shall not offer or give any form of compensation or reward, or engage in any behavior or activity that may be reasonably construed as coercive, to induce or procure Title XXI enrollment. A contractor may make program applications available, but shall not assist with the completion of an application or suggest that an applicant enroll with particular contractor. Any marketing solicitation offering a benefit, good, or service, in excess of the covered services in 9 A.A.C. 31, Article 2 shall be deemed an inducement.

**B.** Any person or entity acting as the contractor's marketing agent shall not misrepresent itself, the contractor represented, or the program, through false advertising, false statements, or in any other manner to induce a member of a current contractor to enroll with the prospective contractor. The Administration shall deem violations of this subsection to include, false or misleading claims, inferences, or representations that:
1. A member will lose benefits under the program or any other health or welfare benefits to which the member is legally entitled, if the member does not enroll with the prospective contractor;
2. Marketing representatives are employees of the state or representatives of the Administration, a county, or any contractor other than the contractor with whom they are employed, or by whom they are reimbursed; and
3. The represented contractor is recommended or endorsed as superior to its competition by any state or county agency, or any organization, unless the organization has certified its endorsement in writing to the contractor and the Administration.

**C.** Any person or entity acting as the contractor's marketing agent shall not engage in any marketing or pre-enrollment practice that discriminates against a member because of race, creed, age, color, sex, religion, national origin, ancestry, marital status, sexual preference, physical or mental disability, or health status.

**D.** The Administration shall hold a contractor responsible for the performance of any person or entity acting as the contractor's marketing agent, subcontractor or agent, program, or process under its employ or direction and shall make the contractor subject to the contract sanctions in 9 A.A.C. 31, Article 6.

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4).

**R9-31-505. Approval of Advertisements and Marketing Materials**

**A.** A contractor shall submit its proposed advertisements, marketing materials, and paraphernalia for review and approval by the Administration before distributing the materials or implementing the activities.

**B.** A contractor shall submit all proposed marketing materials in writing to the Administration.

**C.** The Administration shall review and approve or disapprove all marketing materials. The Administration shall include a statement of objections and recommendations in a notice of disapproval.

**D.** To minimize the expense of revising advertising or other copy, a contractor may submit the marketing materials in draft form, subject to final approval and filing of a proof or final copy.

**E.** A contractor shall provide two copies of the proof or final approved copy of marketing materials to the Administration.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

**R9-31-506. Reserved**

**R9-31-507. Member Record**

As specified in A.R.S. § 36-2986, a contractor shall maintain a member service record that contains at least the following for each member:

1. Encounter data,
2. Grievances and requests for hearing,
3. Any informal complaints, and
4. Service information.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4).

**R9-31-508. Limitation of Benefit Coverage for Illness or Injury due to Catastrophe**

The Director may limit the scope of health care benefits provided by a prepaid capitated contractor to exclude the care of illness or injury that results from, or is greatly aggravated by, a catastrophic occurrence, including an act of declared or undeclared war, that occurs after enrollment.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

**R9-31-509. Transition and Coordination of Member Care**

**A.** As specified in A.R.S. § 36-2986, the Administration shall coordinate and implement disenrollment and re-enrollment procedures if a member's change of residency requires a change in contractor.

**B.** A contractor shall assist in the transition of members to and from other contractors.

1. Both the receiving and relinquishing contractor shall:
   a. Coordinate with the other contractor to facilitate and schedule appointments for medically necessary services for the transitioned member within the Administration's timelines specified in the contract. A contractor's policies and procedures regarding transition of members are subject to review and approval by the Administration;
   b. Assist in the referral of transitioned members to other community health agencies or county medical assistance programs for medically necessary services not covered by the Administration, as appropriate; and
   c. Develop policies and procedures for transitioning members who have significant medical conditions, are receiving ongoing services, or have, at the time of the transition, received prior authorization or approval for undelivered, specific services.
2. The relinquishing contractor shall notify the receiving contractor of relevant information about the member's medical condition and current treatment regimens within the timelines defined in contract.
3. The relinquishing contractor shall forward medical records and other materials regarding the member's medical condition to the receiving contractor. The cost of reproducing and forwarding medical records and other materials shall be borne by the relinquishing contractor.
4. Within the contract-specified timelines, the receiving contractor shall ensure that the member selects or is assigned to a primary care provider, and provide the member with:
   a. Information regarding the contractor's providers,
   b. Emergency numbers, and
   c. Instructions about how to obtain new services.

**C.** A contractor shall not use a county or noncontracting provider health resource alternative that diminishes the contractor's contractual responsibility or accountability for providing the full scope of covered services. The Administration may sanction a contractor under 9 A.A.C. 31, Article 6 for referrals made to other health agencies by the contractor, primarily to reduce expenditures incurred by the contractor on behalf of its members.

**D.** A contractor may transfer a member as specified in A.R.S. § 36-2986, from a noncontracting provider to a contracting provider's facility if a transfer will not be harmful to the member's health as authorized by the member's primary care provider or the contractor's medical director. A member's contractor shall pay the cost of transfer.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4).

**R9-31-510. Transfer of Members**

As specified in A.R.S. § 36-2989, a contractor shall implement procedures to allow a member to transfer from the primary care provider of record to another primary care provider within the same contracting organization. Criteria for a transfer include, but are not be limited to:

1. Change in the member's health, requiring a different medical focus;
2. Change in the member's residency resulting in difficulty in obtaining services from the assigned primary care provider; or
3. Identification of any problem between the member and the primary care provider, resulting in deterioration of the primary care provider-member relationship.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

**R9-31-511. Fraud or Abuse**

As specified in A.R.S. §§ 36-2986 and 36-2992, a contractor, provider, or noncontracting provider shall advise the Director or designee immediately, in writing, of any case of suspected fraud or abuse.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4).

**R9-31-512. Release of Safeguarded Information by the Administration and Contractors**

**A.** The Administration, a contractor, a provider, and a noncontracting provider shall safeguard information concerning an applicant or member which includes the following:
1. Name and address;
2. Social Security number;
3. Social and economic conditions or circumstances;
4. Agency evaluation of personal information;
5. Medical data and services, including diagnosis and history of disease or disability;
6. State Data Exchange (SDX) tapes from the U.S. Social Security Administration; and
7. Information system tapes from the Arizona Department of Economic Security.

**B.** The restriction upon disclosure of information does not apply to:
1. Summary data,
2. Statistics,
3. Utilization data, and
4. Other information that does not uniquely identify an applicant or member.

**C.** The Administration, a contractor, a provider, and a noncontracting provider shall use or disclose information concerning an applicant or member only under the conditions specified in subsections (D), (E), and (F) and only to:
1. The person concerned,
2. Individuals authorized by the person concerned, and
3. Persons or agencies for official purposes.

**D.** Safeguarded information shall be viewed by or released for only:
1. An applicant;
2. A member; or
3. An unemancipated minor, with written permission of a parent, custodial relative, or designated representative, if:
   a. An Administration employee or its authorized representative, or responsible caseworker is present during the examination of the eligibility record; or
   b. As outlined in subsection (E) after written notification to the provider, and at a reasonable time and place.
4. A purpose as specified in R9-31-512(F).

**E.** An eligibility case record, medical record, and any other Title XXI-related confidential and safeguarded information regarding a member, applicant, or unemancipated minor shall be released to individuals authorized by the member, applicant, or unemancipated minor only under the following conditions:
1. Authorization for release of information is obtained from the member, applicant, or designated representative;
2. Authorization used for release is a written document, separate from any other document, that specifies the following information:
   a. Information or records, in whole or in part, which are authorized for release;
   b. To whom release is authorized;
   c. The period of time for which the authorization is valid, if limited; and
   d. A dated signature of the adult and mentally competent member, applicant, or designated representative. If the member, or applicant is a minor, the signature of a parent, custodial relative, or designated representative shall be required. If the member, or applicant is mentally incompetent, authorization shall be according to A.R.S. § 36-509;
3. If an appeal or grievance is filed, the member, applicant, or designated representative shall be permitted to review and obtain or copy any nonprivileged record necessary for the proper presentation of the case.

**F.** Release of safeguarded information to individuals or agencies for official purposes:
1. Official purposes directly related to the administration of the Title XXI program include:
   a. Establishing eligibility and premiums, as applicable;
   b. Determining the amount of medical assistance;
   c. Providing services for members;
   d. Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the Title XXI program;
   e. Performing evaluations and analyses of Title XXI operations;
   f. Filing liens on property, as applicable;
   g. Filing claims on estates, as applicable; and
   h. Filing, negotiating, and settling medical liens and claims.
2. For official purposes related to the administration of the Title XXI program and only to the extent required in performance of duties, safeguarded information, including case records and medical records, may be disclosed to the following persons without the consent of the applicant or member:
   a. Employees of the Administration;
   b. Employees of the U.S. Social Security Administration;
   c. Employees of the Arizona Department of Economic Security;
   d. Employees of the Arizona Department of Health Services;
   e. Employees of the U.S. Department of Health and Human Services;
   f. Employees of contractors, providers, and subcontractors;
   g. Employees of the Arizona Attorney General's Office; or
   h. Qualifying community health centers as specified in A.R.S. § 36-2907.06 and hospitals as specified in A.R.S. § 36-2907.08.
3. Law enforcement officials:
   a. Information may be released to law enforcement officials without the applicant's, or member's written or verbal consent, for the purpose of an investigation, prosecution, or criminal or civil proceeding relating to the administration of the Title XXI program.
   b. Medical record. The Administration and contractors shall release safeguarded information contained in a member's medical record to law enforcement officials without the member's consent in situations of suspected of fraud or abuse against the Title XXI program.

c. A contractor shall release the medical record or information in the case record or other information developed in case management or utilization management operations without the member's written or verbal consent, for the purpose of an investigation, prosecution, or similar criminal proceeding not in connection with the Administration, only if the law enforcement official requesting the information has statutory authority to obtain the information.

4. The Administration may release safeguarded information including case records and medical records to a review committee in accordance with the provisions of A.R.S. § 36-2986, without the consent of the applicant or member.
5. Providers shall furnish requested records to the Administration and its contractors at no charge.

**G.** The holder of a medical record of a former applicant or member shall obtain written consent from the former applicant or member before transmitting the medical record to a primary care provider.

**H.** Subcontractors are not required to obtain written consent from a member before transmitting the member's medical records to a physician who:
1. Provides a service to the member under subcontract with the program contractor,
2. Is retained by the subcontractor to provide services that are infrequently used or are of an unusual nature, and
3. Provides a service under the contract.

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

**R9-31-513. Discrimination Prohibition**

**A.** A contractor, provider, or noncontracting provider shall not discriminate against a member:
1. Under Title VI of the U.S. Civil Rights Act of 1964, 42 U.S.C. 2000d,
2. Because of:
   a. Marital status,
   b. Sexual preference,
   c. Age,
   d. Sex, or
   e. Behavioral disability, or
3. In violation of any other rule or regulation provided by law.

**B.** For the purpose of providing a covered service under contract according to A.R.S. Title 36, Ch. 29, discrimination includes, the following if done on the grounds subsection (A).
1. Denying or providing a member any covered service or availability of a facility;
2. Providing to a member any covered service that is different, or is provided in a different manner or at a different time from that provided to other members under contract, other public or private members, or the public at large except when medically necessary;
3. Subjecting a member to segregation or separate treatment in any manner related to the receipt of any covered service;
4. Restricting a member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any covered service; and
5. Assigning to a member times or places for the provision of services that are different from those assigned to other members.

**C.** A contractor shall take affirmative action to ensure that members are provided covered services without discrimination under Section (A) except where medically indicated.

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4).

**R9-31-514. Equal Opportunity**

A contractor shall, in all solicitations or advertisements for employees placed by, or, on behalf of the contractor:
1. Specify that it is an equal opportunity employer;
2. Send a notice provided by the Administration to each labor union representative or worker with a collective bargaining agreement, or other contract or understanding, stating that the contractor is an equal opportunity employer; and
3. Post copies of the notice in conspicuous places available to employees and applicants for employment.

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

**R9-31-515. Reserved**

**R9-31-516. Reserved**

**R9-31-517. Reserved**

**R9-31-518. Information to Enrolled Members**

**A.** As specified in A.R.S. § 36-2986, each contractor shall produce and distribute printed information materials to each member within 10 days of receipt of notification of enrollment from the Administration. The information materials shall be written in English and all languages used by 200 members or 5%, whichever is greater, of the enrolled population. The information materials must meet the requirements specified in the contractor's current contract.

**B.** A contractor shall provide a member with the name, address, and telephone number of the member's primary care provider within 10 days from the date of enrollment. This notice shall include information on how the member may change primary care providers, if dissatisfied with the primary care provider assigned.

**C.** A contractor shall revise and distribute to members a service guide insert describing any change that the contractor proposes to make in services provided or service locations. The insert shall be distributed to all affected members at least 14 days before a planned change. Notification shall be provided as soon as possible when unforeseen circumstances require an immediate change in services, sites or locations.

**D.** A contractor shall submit informational and educational materials for approval by the Administration before distributing the materials to members.

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

**R9-31-519. Reserved**

**R9-31-520. Financial Statements, Periodic Reports, and Information**

**A.** Upon request by the Administration, a contractor shall furnish to the Administration information from its records relating to contract performance.

**B.** A contractor shall provide the Administration with the following:
1. An annual certified financial report prepared by a certified public accountant submitted no later than 120 days after the close of the contractor's fiscal year. The certified public accountants who prepare the report shall be independent of the contractor, subcontracting entities, their officers or directors, and any affiliates.
2. Quarterly financial statements no later than 60 days after the end of the reporting month.
3. Monthly financial statements, if required by the Administration submitted no later than 60 days after the end of the reporting period.
4. Disclosure of information on ownership and control required by 42 CFR 455, Subpart B, September 30, 1986, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.
5. Cost reporting, audits, and financial reporting as specified in contract or provider agreement.

**C.** All financial statements shall identify separately all AHCCCS related transactions, including allocations of overhead and other shared expenses where applicable. A contractor shall provide supplemental schedules describing all inter-entity transactions and eliminations for the Administration to use in analyzing the financial status of the entire health care delivery system.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

**R9-31-521. Program Compliance Audits**

**A.** As specified in A.R.S. § 36-2986, the Administration shall conduct a program compliance audit of a contractor at least once every 12 months during the term of its contract with the contractor. Unless the Administration determines that advance notice will render a program compliance audit less useful, a contractor shall be notified at least three weeks in advance of the date of an onsite program compliance audit. The Administration may conduct, without prior notice, inspections of contractor facilities or perform other elements of a program compliance audit, either in conjunction with the program compliance audit or as part of an unannounced inspection program.

**B.** The Administration's review team may perform any or all of the following procedures:
1. Conduct private interviews and group conferences with members, physicians, and other health professionals and members of a contractor's administrative staff including, but not limited to, the contractor's principal management persons;
2. Examine records, books, reports, and papers of a contractor and any management company, and all providers or subcontractors providing health care and other services to the contractor. The examination may include, but not be limited to: minutes of medical staff meetings, peer review and quality of care review records, duty rosters of medical personnel, appointment records, written procedures for the internal operation of the contractor, contracts and correspondence with members and with providers of health care services and other services to the plan, and additional documentation deemed necessary by the Administration to review the quality of medical care.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4).

**R9-31-522. Quality Management/Utilization Management (QM/UM) Requirements**

**A.** As specified in A.R.S. §§ 36-2986 and 36-2990, a contractor shall comply with Quality Management/Utilization Management (QM/UM) requirements specified in this Section and in contract. The contractor shall ensure compliance with QM/UM requirements that are accomplished through delegation or subcontract with another party.

**B.** A contractor shall:
1. Submit a written QM/UM plan that includes a description of the systems, methodologies, protocols, and procedures to be used in:
   a. Monitoring and evaluating the types of services,
   b. Identifying the numbers and costs of services provided,
   c. Assessing and improving the quality and appropriateness of care and services,
   d. Evaluating the outcome of care provided to members, and
   e. Determining the steps and actions necessary to improve service delivery.
2. Submit the QM/UM plan on an annual basis within timelines specified in contract. If the QM/UM plan is changed during the year, the contractor shall submit the revised plan before implementation;
3. Receive approval from the Administration before implementing the initial QM/UM plan;
4. Ensure that a QM/UM committee operates under the control of the contractor's medical director, and includes representation from medical and executive management personnel. The committee shall:
   a. Oversee the development, revision and implementation of the QM/UM plan; and
   b. Ensure and allocate qualified QM/UM personnel and sufficient resources to implement the contractor's QM/UM activities.
5. Ensure that the QM/UM activities include at least:
   a. Prior authorization for non-emergency or scheduled hospital admissions;
   b. Concurrent review of inpatient hospitalization;
   c. Retrospective review of hospital claims;
   d. Program and provider audits designed to detect over or under utilization, service delivery effectiveness, and outcome;
   e. Medical records audits;
   f. Surveys to determine satisfaction of members;
   g. Assessment of the adequacy and qualifications of the contractor's provider network;
   h. Review and analysis of QM/UM data; and
   i. Other activities necessary to improve the quality of care and the efficient, cost effective delivery and utilization of services.

**C.** A member's primary care provider shall maintain medical records that:
1. Are detailed and comprehensive and identify:
   a. All medically necessary services provided to the member by the contractor and the subcontractors, and
   b. All emergency services provided by nonproviders for a member.

2. Conform to professional medical standards and practices for documentation of medical diagnostic and treatment data,
3. Facilitate follow-up treatment, and
4. Permit professional medical review and medical audit processes.

**D.** A subcontractor or its designee shall forward medical records or copies of medical records of all members assigned to the subcontractor or for whom the subcontractor has provided services, within 30 days following termination of a contract between the subcontractor and the contractor.

**E.** The Administration shall monitor contractors and their providers to ensure compliance with Administration QM/UM requirements and adherence to the contractor QM/UM plan.
1. A contractor and its providers shall cooperate with the Administration in the performance of its QM/UM monitoring activities, and
2. A contractor and its providers shall develop and implement mechanisms for correcting deficiencies identified through the Administration's QM/UM monitoring.

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

**R9-31-523. Financial Resources**

**A.** As specified in A.R.S. § 36-2986, a contractor or offeror shall demonstrate upon request to the Administration that it has:
1. Adequate financial reserves,
2. Administrative abilities, and
3. Soundness of program design to carry out its contractual obligations.

**B.** As specified in A.R.S. § 36-2986, the Director requires that contract provisions include, but not be limited to:
1. Maintenance of deposits,
2. Performance bonds,
3. Financial reserves, or
4. Other financial security.

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

**R9-31-524. Continuity of Care**

As specified in A.R.S. § 36-2986, a contractor shall establish and maintain a system to ensure continuity of care which shall, at a minimum, include:
1. Referring members who need specialty health care services,
2. Monitoring members with chronic medical conditions,
3. Providing hospital discharge planning and coordination including post-discharge care, and
4. Monitoring operation of the system through professional review activities as specified in A.R.S. § 36-2986.

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

**R9-31-525. Reserved**

**R9-31-526. Reserved**

**R9-31-527. Reserved**

**R9-31-528. Reserved**

**R9-31-529. Reserved**

## ARTICLE 6. RFP AND CONTRACT PROCESS

**R9-31-601. General Provisions**

**A.** The Director has full operational authority to adopt rules and to use the appropriate rules for contract administration and oversight of contractors under A.R.S. § 36-2986. The Administration shall administer the program under A.R.S. § 36 - 2982.

**B.** The Administration shall award contracts under A.R.S. § 36-2986 to provide services under A.R.S. § 36-2989.

**C.** The Administration shall follow the provisions under 9 A.A.C. 22, Article 6 for members, unless otherwise specified in this Chapter.

**D.** The Administration is exempt from the procurement code under A.R.S. § 36-2988 and § 41-2501.

**E.** The Administration and contractors shall retain all contract records for five years under A.R.S. § 36-2986 and dispose of the records under A.R.S. § 41-2550.

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Amended by final rulemaking at 8 A.A.R. 452, effective January 10, 2002 (Supp. 02-1).

**R9-31-602. RFP**

The RFP for a contractor serving members who qualify for the program shall be under A.R.S. § 36-2986 and A.A.C. R9-22-602.

**Historical Note**
New Section made by final rulemaking at 8 A.A.R. 452, effective January 10, 2002 (Supp. 02-1).

**R9-31-603. Contract Award**

The contract award shall be under A.R.S. § 36-2986 and A.A.C. R9-22-603.

**Historical Note**
New Section made by final rulemaking at 8 A.A.R. 452, effective January 10, 2002 (Supp. 02-1).

**R9-31-604. Contract or Proposal Protests; Appeals**

Contract or proposal protests or appeals shall be under A.A.C. R9-22-604.

**Historical Note**
New Section made by final rulemaking at 8 A.A.R. 452, effective January 10, 2002 (Supp. 02-1).

**R9-31-605. Waiver of Contractor's Subcontract with Hospitals**

A waiver of a contractor's subcontract with a hospital shall be under A.A.C. R9-22-605.

**Historical Note**
New Section made by final rulemaking at 8 A.A.R. 452, effective January 10, 2002 (Supp. 02-1).

**R9-31-606. Contract Compliance Sanction**

The Administration shall follow sanction provisions under A.A.C. R9-22-606.

**Historical Note**
New Section made by final rulemaking at 8 A.A.R. 452, effective January 10, 2002 (Supp. 02-1).

## ARTICLE 7. STANDARDS FOR PAYMENTS

### R9-31-701. Scope of the Administration's Liability

**A.** The Director has full operational authority to adopt rules and to use the appropriate rules adopted for the development and management of a contractor payment system under A.R.S. §§ 36-2986 and 36-2987.

**B.** If the federal government eliminates federal funding for the program or significantly reduces the federal funding below the estimated federal expenditures, the Administration shall immediately stop processing all applications and shall provide at least 30 days advance notice to contractors and members that the program will terminate under A.R.S. § 36-2985.

**C.** The Administration shall bear no liability for providing covered services to or completing a plan of treatment for any member beyond the date of termination of the member's eligibility.

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 452, effective January 10, 2002 (Supp. 02-1).

### R9-31-702. Prohibitions Against Charges to Members

**A.** Except as provided in subsection (B), an AHCCCS registered provider shall not do either of the following, unless services are not covered or without first receiving verification from the Administration that the person was ineligible for AHCCCS on the date of service:
1. Charge, submit a claim to, demand or collect payment from a person claiming to be AHCCCS eligible; or
2. Refer or report a person claiming to be AHCCCS eligible to a collection agency or credit reporting agency.

**B.** An AHCCCS registered provider may charge, submit a claim to, demand or collect payment from a member as follows:
1. To collect an authorized copayment;
2. To pay for non-covered services;
3. To recover from a member that portion of a payment made by a third-party to the member if the payment duplicates AHCCCS paid benefits and is not assigned to a contractor under R9-31-1002(B). An AHCCCS registered provider that makes a claim under this Article shall not charge more than the actual, reasonable cost of providing the covered service; or
4. To bill a member for medical expenses incurred during a period when the member intentionally withheld information or intentionally provided inaccurate information pertaining to the member's AHCCCS eligibility or enrollment that caused the payment to the provider to be reduced or denied.

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 3350, effective July 15, 2002 (Supp. 02-3).

### R9-31-703. Claims

**A.** Claims submission to contractors. An AHCCCS registered provider shall submit to a contractor all claims for services rendered to a member enrolled with the contractor as specified in R9-31-705.

**B.** Overpayments for AHCCCS Services.
1. An AHCCCS registered provider shall notify the Administration when the provider discovers an overpayment was made by the Administration.
2. The Administration shall recoup an overpayment from a future claim cycle if an AHCCCS registered provider fails to return the incorrect payment amount to the Administration.

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Amended by final rulemaking at 8 A.A.R. 3350, effective July 15, 2002 (Supp. 02-3).

### R9-31-704. Transfer of Payments

**A.** Billing agent. For purposes of this Section, a business agent is a firm such as a billing service or accounting firm that renders statements and receives payment in the name of the contractor or AHCCCS registered provider.

**B.** Allowable transfer of payments. The Administration or the contractor may make payments to other than the AHCCCS registered provider, and the Administration may make payments to other than the contractor after considering whether:
1. There is an assignment to a government agency or an assignment under a court order; or
2. A business agent's compensation is:
   a. Related to the cost of processing the statements; and
   b. Not dependent upon the actual collection of payment.

**C.** Prohibition of transfer of payments to factors. The Administration shall not make payment for covered services furnished to a member by a contractor or an AHCCCS registered provider to, or through a factor, either directly, or by virtue of a power of attorney given to the factor.

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 3350, effective July 15, 2002 (Supp. 02-3).

### R9-31-705. Payments by Contractors

**A.** Authorization. A contractor shall pay for all admissions and covered services rendered to its members if the covered services or admissions have been arranged by the contractor's agents or employees, subcontracting providers, or other individuals acting on the contractor's behalf and if necessary authorization has been obtained. A contractor is not required to pay a claim for covered services that is submitted more than six months after the date of the service or that is submitted as a clean claim more than 12 months after the date of the service.

**B.** Timeliness of provider claim payment.
1. A contractor shall reimburse, or provide written notice for a claim that is denied or reduced by a contractor, to a subcontracting provider for the provision of medically necessary health care services to a contractor's member, within the time period specified by the subcontract.
2. Unless the subcontract specifies otherwise, a contractor shall pay valid clean claims according to 42 U.S.C. 1396u-2, as of August 5, 1997, which is incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by

reference contains no future editions or amendments and states that:
a. 90% of valid claims shall be paid within 30 days of the date of receipt of a claim,
b. 99% of valid clean claims shall be paid within 90 days of the date of receipt of a claim, and
c. The remaining 1% of valid clean claims shall be paid within 12 months of the date of receipt of a claim.

3. Unless the subcontract specifies otherwise, a contractor shall provide notice of a denial or a reduction of a claim for:
a. 90% of the claims within 30 days of the date of receipt of a claim,
b. 99% of the claims within 90 days of the date of receipt of a claim, and
c. The remaining 1% of the claims within 12 months of the date of receipt of a claim.

4. A notice of denial or reduction shall include a statement describing the right to grieve the contractor's denial or reduction of a claim according to 9 A.A.C. 22, Article 8.

**C.** Date of claim. A contractor's date of receipt of an inpatient or outpatient hospital claim shall be the date the claim is received by the contractor as indicated by the date stamp on the claim, the claim reference number, or the date-specific number system assigned by the contractor. A hospital claim shall be considered paid on the date indicated on the disbursement check. A denied hospital claim shall be considered adjudicated on the date of its denial. Claims that are pending for additional supporting documentation will receive new dates of receipt upon receipt of the additional documentation; however, claims that are pending for documentation other than the minimum required documentation specified in either A.R.S. §§ 36-2987 or 36-2904, as applicable, will not receive new dates of receipt. A contractor and a hospital may, through a contract approved in accordance with R9-31-715(A), adopt a method for identifying, tracking, and adjudicating claims that is different from the method described in this subsection.

**D.** Payment for medically necessary outpatient hospital services.
1. A contractor shall reimburse subcontracting and noncontracting providers for the provision of outpatient hospital services rendered at either a rate specified by subcontract or, in absence of a subcontract, the AHCCCS hospital-specific outpatient cost-to-charge ratio multiplied by covered charges. Subcontract rates, terms, and conditions are subject to review, and approval or disapproval under A.R.S. §§ 36-2987, 36-2904, and R9-31-715.
2. A contractor shall pay for all emergency care services rendered to its members by noncontracting providers or nonproviders when the services:
a. Are rendered according to the prudent layperson standard,
b. Conform to the definitions of emergency medical and acute mental health services in Article 1 of this Chapter, and
c. Conform to the notification requirements in Article 2 of this Chapter.

**E.** Payment for inpatient hospital services. A contractor shall reimburse out-of-state hospitals for the provision of hospital services at negotiated discounted rates, the AHCCCS average cost-to-charge ratio multiplied by covered charges or, if reasonably and promptly available, the Medicaid rate that is in effect at the time services are provided in the state in which the hospital is located, whichever is lowest. A contractor shall reimburse in-state subcontractors and noncontracting providers for the provision of inpatient hospital services at either a rate specified by subcontract or, in absence of a subcontract, the prospective tiered-per-diem amount in A.R.S. §§ 36-2987, 36-2904, 36-2903.01, and A.A.C. R9-22-712 and R9-22-718, as applicable. Discounts and penalties shall be as specified in A.R.S. § 36-2987(C). Subcontract rates, terms, and conditions are subject to review and approval or disapproval under A.R.S. §§ 36-2987, 36-2904, and R9-31-715.

**F.** Payment for observation days. A contractor may reimburse subcontracting and noncontracting providers for the provision of observation days at either a rate specified by subcontract or, in the absence of a subcontract, the AHCCCS hospital-specific outpatient cost-to-charge ratio multiplied by covered charges.

**G.** Review of hospital claims.
1. If a contractor and a hospital do not agree on reimbursement levels, terms, and conditions, the reimbursement levels established under A.R.S. §§ 36-2987, 36-2904, 36-2903.01, and A.A.C. R9-22-712 or R9-31-718 shall apply. In these cases, a hospital shall obtain prior authorization from the appropriate contractor for nonemergency admissions. A contractor shall consider the medical condition of the member, length of stay, and other factors when issuing its prior authorization. If a contractor and a hospital agree to a subcontract, the parties shall abide by the terms of their contract regarding utilization control activities that may include prior authorization of nonemergency admissions. Failure to obtain prior authorization when it is required shall be cause for nonpayment or denial of the claim. A hospital shall cooperate with a contractor's reasonable activities necessary to perform concurrent review and make the hospital's medical records, specific to a member enrolled with the contractor, available for review.
2. Regardless of prior authorization or concurrent review activities, all hospital claims, including outlier claims, are subject to prepayment medical review and post-payment review by the contractor. Post-payment reviews shall be consistent with A.R.S. § 36-2987, and erroneously paid claims are subject to recoupment. If prior authorization was given for a specific level of care, but medical review of the claim indicates that a different level of care was appropriate, the contractor may adjust the claim to reflect the more appropriate level of care. An adjustment in level of care shall be effective on the date when the different level of care was medically appropriate.
3. A contractor and a hospital may enter into a subcontract that includes hospital claims review criteria and procedures different from those in this subsection if the subcontract binds both parties and meets the requirements of R9-31-715.

**H.** Timeliness of hospital claim payment. Payment by a contractor for inpatient hospital admissions and outpatient hospital services shall be subject to A.R.S. §§ 36-2987, 36-2904, and 36-2903.01.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3).

**R9-31-706. Reserved**

**R9-31-707. Payments for Newborns**

If a mother is enrolled on the date of her newborn baby's birth, a contractor shall be financially liable under the mother's capitation to provide all Title XXI-covered services to the newborn baby from the date of birth until the Administration is notified of the birth.

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

**R9-31-708. Reserved**

**R9-31-709. Contractor's Liability to Hospitals for the Provision of Emergency and Subsequent Care**
A contractor's liability to hospitals for the provision of emergency and subsequent care shall be under A.R.S. § 36-2989, A.A.C. R9-22-709, R9-31-705, and Article 2 of this Chapter.

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 452, effective January 10, 2002 (Supp. 02-1).

**R9-31-710. Reserved**

**R9-31-711. Copayments**
An individual determined eligible under this Chapter shall comply with A.A.C. R9-22-711.

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Amended by final rulemaking at 8 A.A.R. 3350, effective July 15, 2002 (Supp. 02-3). Amended by exempt rulemaking at 9 A.A.R. 4560, effective October 1, 2003 (Supp. 03-4).

**R9-31-712. Reserved**

**R9-31-713. Payments Made on Behalf of a Contractor; Recovery of Indebtedness**

**A.** The Administration may make payments on behalf of a contractor in order to prevent a suspension or termination of AHCCCS services after considering whether:
1. A contractor does not adjudicate a valid accrued claim within the period set forth under subcontract, or
2. A contractor does not adjudicate 99 percent of valid accrued claims within 90 days of receipt from the AHCCCS registered provider.

**B.** If a contractor or a subcontracting provider receives an overpayment or otherwise becomes indebted to the Administration, the contractor or subcontracting provider shall immediately remit the amount of the indebtedness or overpayment to the Administration for deposit in the Children's Health Insurance Program Fund.

**C.** The Administration may recover the indebtedness or overpayment from a contractor or a subcontracting provider in circumstances including the following:
1. Negotiation of a repayment agreement executed with the Administration,
2. Withholding or offsetting against current or future prepayments or other payments to be paid to the contractor or subcontracting provider, or
3. Enforcement of, or collection against, the performance bond, deposit, financial reserve, or other financial security under A.R.S. § 36-2986.

**D.** Except as specifically provided for in this Article, the Administration is not liable for payment for medical expenses incurred by members enrolled with contractors.

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 3350, effective July 15, 2002 (Supp. 02-3).

**R9-31-714. Payments to Providers**
The Administration shall pay providers under A.A.C. R9-22-714.

**Historical Note**
New Section made by final rulemaking at 8 A.A.R. 452, effective January 10, 2002 (Supp. 02-1).

**R9-31-715. Hospital Rate Negotiations**

**A.** Effective for inpatient hospital admissions and outpatient hospital services contractors that negotiate with hospitals for inpatient or outpatient services shall reimburse hospitals for member care based on the prospective tiered-per-diem amount, the AHCCCS hospital-specific outpatient cost-to-charge ratio multiplied by covered charges in A.R.S. § 36-2987 and A.A.C. R9-22-712, or the negotiated rate that, when considered in the aggregate with other hospital reimbursement levels, does not exceed what would have been paid under A.R.S. § 36-2987 and A.A.C. R9-22-712.
1. Contractors may engage in rate negotiations with hospitals at any time during the contract period.
2. Within seven days of the completion of the agreement process, contractors shall submit copies of their negotiated rate agreements, including all rates, terms, and conditions, with hospitals to the Administration for approval. Contractors shall demonstrate to the Administration that the effect of their negotiated rate agreement will, when considered in the aggregate, be the same as or produce greater dollar savings than would have been paid under A.R.S. § 36-2987 and A.A.C. R9-22-712.
   a. To demonstrate the aggregate effect of its negotiated rate agreement, contractors shall present their assumptions related to projected utilization of various hospitals to the Administration. The contractor may consider inpatient assumptions related to:
      i. Member mix;
      ii. Admissions by AHCCCS-specified tiers;
      iii. Average length of stay by tier and pattern of admissions, excluding emergency admissions;
      iv. Outliers; and
      v. Risk-sharing arrangements.
   b. The contractor also may consider outpatient assumptions related to member mix and outpatient service utilization. The Administration reserves the right to approve, deny, or require mutually-agreed-to modifications of these assumptions.
   c. When a contractor adjusts or modifies an assumption, the reason for the adjustment or modification shall be presented to the Administration, as well as the new assumption. The Administration may approve, deny, or require mutually-agreed-to modification of an assumption.
   d. To determine whether a negotiated rate agreement produces reimbursement levels that do not in the aggregate exceed what would be paid under A.R.S. § 36-2987 and A.A.C. R9-22-712, a contractor shall require its independent auditors to evaluate the reasonableness of its assumptions as part of its annual audit. The contractor shall ensure that its independent auditor's audit program is consistent with AHCCCS audit requirements and is submitted to the Administration for prior approval.

e. Negotiated inpatient or outpatient rate agreements with hospitals with a contractor has a related-party interest are subject to additional related party disclosure and evaluation. These evaluations are in addition to the procedures described in subsection (A)(2)(c) and shall be performed by the contractor's independent auditors, or, at the contractor's option, by the Administration.

f. The Administration shall subject a contractor's independent auditor's report to any examination or review necessary to ensure accuracy of all findings related to aggregate rate determinations.

g. The Administration shall use its standards, consistent with the Request for Proposals and R9-31-502, to determine whether a contractor's inpatient or outpatient hospital subcontractors will limit the availability or accessibility of services. The Administration reserves the right to reject hospital subcontracts that limit the availability or accessibility of services.

**B.** The Administration may negotiate or contract with a hospital on behalf of a contractor for discounted hospital rates and may require that the negotiated discounted rates be included in a subcontract between the contractor and hospital.

**C.** The Director shall apportion any cost avoidance in the hospital component of provider capitation rates between the Administration and provider. The Administration's portion of the cost avoidance shall be reflected in reduced capitation rates paid to providers.

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

**R9-31-716. Specialty Contracts**
The Director may negotiate specialty contracts under A.A.C. R9-22-716.

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 452, effective January 10, 2002 (Supp. 02-1).

**R9-31-717. Hospital Claims Review**

**A.** The contractors shall review hospital claims that are timely received as specified in A.A.C. R9-22-703(A).

**B.** A charge for hospital services provided to a member during a time when the member was not the financial responsibility of the contractor shall be denied.

**C.** Personal care items supplied by a hospital, including but not limited to the following, are not covered services:
1. Patient care kit,
2. Toothbrush,
3. Toothpaste,
4. Petroleum jelly,
5. Deodorant,
6. Septi soap,
7. Razor,
8. Shaving cream,
9. Slippers,
10. Mouthwash,
11. Disposable razor,
12. Shampoo,
13. Powder,
14. Lotion,
15. Comb, and
16. Patient gown.

**D.** The following hospital supplies and equipment, if medically necessary and used, are covered services:
1. Arm board,
2. Diaper,
3. Underpad,
4. Special mattress and special bed,
5. Gloves,
6. Wrist restraint,
7. Limb holder,
8. Disposable item used in lieu of a durable item,
9. Universal precaution,
10. Stat charge, and
11. Portable charge.

**E.** The hospital claims review shall determine whether services rendered were:
1. Title XXI-covered services;
2. Medically necessary;
3. Provided in the most appropriate, cost-effective, least restrictive setting; and
4. Substantiated by the minimum documentation specified in A.R.S. § 36-2987.

**F.** If a claim is denied by the contractor, a grievance challenging the denial may be filed against the entity denying the claim. The grievance shall be filed no later than 12 months from the date of service or 60 days from the date of notice of adverse action, whichever is latest. Any grievance challenging a post-payment review recoupment action shall be filed by the provider no later than 12 months from the date of service or 60 days from the date of the notice of recoupment, whichever is latest.

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3).

**R9-31-718. Contractor Performance Measure Outcomes**
Contractor performance measure outcomes shall be under A.A.C. R9-22-719.

**Historical Note**
New Section made by final rulemaking at 8 A.A.R. 452, effective January 10, 2002 (Supp. 02-1).

**R9-31-719. Reinsurance**
A contractor shall submit to the Administration all reinsurance claims for services rendered to a member enrolled with the contractor as specified in A.A.C. R9-22-720.

**Historical Note**
New Section made by final rulemaking at 8 A.A.R. 3350, effective July 15, 2002 (Supp. 02-3).

**ARTICLE 8. REPEALED**

*Article 8, consisting of Sections R9-31-801 through R9-31-803 and Exhibit A, repealed by final rulemaking at 10 A.A.R. 822, effective April 3, 2004. The subject matter of Article 8 is now in 9 A.A.C. 34 (Supp. 04-1).*

**R9-31-801. Repealed**

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed; new Section adopted by exempt rulemaking at 6

A.A.R. 3205, effective August 4, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 822, effective April 3, 2004 (Supp. 04-1).

**R9-31-802. Repealed**

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed; new Section adopted by exempt rulemaking at 6 A.A.R. 3205, effective August 4, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 822, effective April 3, 2004 (Supp. 04-1).

**R9-31-803. Repealed**

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed; new Section adopted by exempt rulemaking at 6 A.A.R. 3205, effective August 4, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 822, effective April 3, 2004 (Supp. 04-1).

**R9-31-804. Repealed**

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed by exempt rulemaking at 6 A.A.R. 3205, effective August 4, 2000 (Supp. 00-3).

**Exhibit A. Repealed**

**Historical Note**
New Exhibit adopted by exempt rulemaking at 6 A.A.R. 3205, effective August 4, 2000 (Supp. 00-3). Exhibit repealed by final rulemaking at 10 A.A.R. 822, effective April 3, 2004 (Supp. 04-1).

## ARTICLE 9. QUALITY CONTROL

**R9-31-901. General Provisions**

**A.** The Director has full operational authority to adopt rules or to use the appropriate rules for administration and oversight of quality control as specified in A.R.S. § 36-2986.

**B.** As specified in A.R.S. § 36-2982, the Administration has the authority to establish a process to audit eligibility determinations made by AHCCCS or the entities with which the Administration contracts or enters into an intergovernmental agreement.

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

## ARTICLE 10. FIRST- AND THIRD-PARTY LIABILITY AND RECOVERIES

**R9-31-1001. Definitions**

The definitions in A.R.S. § 36-2981, A.A.C. R9-22-1001, and A.A.C. R9-31-101 apply to this Article.

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Section repealed; new Section made by final rulemaking at 10 A.A.R. 1152, effective May 1, 2004 (Supp. 04-1).

**R9-31-1002. General Provisions**

AHCCCS is the payor of last resort unless specifically prohibited by applicable state or federal law.

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed; new Section made by final rulemaking at 10 A.A.R. 1152, effective May 1, 2004 (Supp. 04-1).

**R9-31-1003. Cost Avoidance**

The provisions in A.A.C. R9-22-1003 apply to this Section except:

1. Replace the reference to "Article 2," with 9 A.A.C. 31, Article 2; and
2. This Section applies to Title XXI covered services.

**Historical Note**
New Section made by final rulemaking at 10 A.A.R. 1152, effective May 1, 2004 (Supp. 04-1).

**R9-31-1004. Member Participation**

The provisions in A.A.C. R9-22-1004 apply to this Section.

**Historical Note**
New Section made by final rulemaking at 10 A.A.R. 1152, effective May 1, 2004 (Supp. 04-1).

**R9-31-1005. Collections**

The provisions in A.A.C. R9-22-1005 apply to this Section except:

1. Replace the reference to "Article 2," with 9 A.A.C. 31, Article 2;
2. This Section applies to Title XXI fee-for-service and reinsurance payments.

**Historical Note**
New Section made by final rulemaking at 10 A.A.R. 1152, effective May 1, 2004 (Supp. 04-1).

**R9-31-1006. AHCCCS Monitoring Responsibilities**

With the exception of long-term care insurance, the provisions in A.A.C. R9-22-1006 apply to this Section.

**Historical Note**
New Section made by final rulemaking at 10 A.A.R. 1152, effective May 1, 2004 (Supp. 04-1).

**R9-31-1007. Notification for Perfection, Recording, and Assignment of Title XXI liens**

The provisions in A.A.C. R9-22-1007 apply to this Section.

**Historical Note**
New Section made by final rulemaking at 10 A.A.R. 1152, effective May 1, 2004 (Supp. 04-1).

**R9-31-1008. Notification Information for Liens**

The provisions in A.A.C. R9-22-1008 apply to this Section.

**Historical Note**
New Section made by final rulemaking at 10 A.A.R. 1152, effective May 1, 2004 (Supp. 04-1).

**R9-31-1009. Notification of Health Insurance Information**

The provisions in A.A.C. R9-22-1009 apply to this Section.

**Historical Note**
New Section made by final rulemaking at 10 A.A.R. 1152, effective May 1, 2004 (Supp. 04-1).

## ARTICLE 11. CIVIL MONETARY PENALTIES AND ASSESSMENTS

### R9-31-1101. Basis for Civil Monetary Penalties and Assessments for Fraudulent Claims

**A.** Establishment and management of a system to prevent fraud. As specified in A.R.S. § 36-2986(A), the Director has full operational authority to adopt rules for the establishment and management of a system to prevent fraud by members, contractors, and health care providers.

**B.** Determination and collection of civil penalties. As specified in A.R.S. §§ 36-2991 and 36-2993 the Director may adopt rules that prescribe procedures for the determination and collection of civil penalties.

**C.** Federal fraud and abuse controls. As specified in A.R.S. § 36-2991, in addition to the requirements of state law, any applicable fraud and abuse controls that are enacted under federal law apply to a person who is eligible for services under this Chapter and to contractors and noncontracting providers who provide services under this Chapter.

**D.** Unpaid civil penalties. As specified in A.R.S. § 36-2991, if a civil penalty imposed according to this Article is not paid, the state may file an action to collect the civil penalty in the superior court in Maricopa county.

**E.** Circumstances for imposing a penalty and assessment. The Director or designee shall impose a penalty and assessment under the circumstances described in A.R.S. § 36-2991. For the purposes of this Article, the term "reason to know" means that a person, with respect to information, acts in deliberate ignorance of the truth or falsity of the information or with reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required.

**F.** Violation of agreement. As specified in A.R.S. § 36-2992, the Director's or designee's determination of whether a person knew or had reason to know that each claim or request for payment was claimed in violation of an agreement with the Administration or a contractor may be based on the terms of the agreement.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

### R9-31-1102. Determinations Regarding the Amount of the Penalty and Assessment

**A.** Factors for determining a penalty and assessment. The Director or designee shall take into account the following factors in determining the amount of a penalty and assessment:
1. The nature of each claim or request for payment and the circumstances under which it is presented,
2. The degree of culpability of a person submitting each claim or request for payment,
3. The history of prior offenses of a person submitting each claim or request for payment,
4. The financial condition of a person presenting each claim or request for payment,
5. The effect on patient care resulting from the failure to provide medically necessary care by a person submitting each claim or request for payment, and
6. Other matters as justice may require.

**B.** Types of claim circumstances. As specified in A.R.S. § 36-2991, in determining the amount of a penalty and assessment, the Director or designee shall consider both mitigating circumstances and aggravating circumstances surrounding submission of each claim or request for payment.

**C.** Mitigating circumstance guidelines. The Director or designee shall consider the following mitigating circumstance guidelines when determining the amount of a penalty and assessment:
1. Nature and circumstances of each claim or request for payment. The nature and circumstances of each claim or request for payment and the circumstances under which it is presented are a mitigating circumstance if:
   a. All the items and services subject to a penalty and assessment are of the same type,
   b. All the items and services subject to a penalty and assessment occurred within a short period of time,
   c. There are few items and services, and
   d. The total amount claimed for the items and services was less than $1,000.
2. Degree of culpability. The degree of culpability of a person submitting a claim or request for payment is a mitigating circumstance if:
   a. Each item or service is the result of an unintentional and unrecognized error in the process the person followed in presenting the item or service,
   b. Corrective steps were taken promptly after the error was discovered, and
   c. A fraud and abuse control plan was adopted and operating effectively at the time each claim or request for payment was submitted.
3. Financial condition. The financial condition of a person presenting a claim or request for payment is a mitigating circumstance if the imposition of a penalty and assessment without reduction will jeopardize the ability of the person to continue as a health care provider. The resources available to the person may be considered when determining the amount of the penalty and assessment; or
4. Other matters as justice may require. Other circumstances of a mitigating nature will be taken into account if, in the interest of justice, the circumstances require a reduction of the penalty and assessment.

**D.** Aggravating circumstance guidelines. The Director or designee shall consider the following aggravating circumstance guidelines when determining the amount of a penalty and assessment:
1. Nature and circumstances of each claim or request for payment. The nature and circumstances of each claim or request for payment and the circumstances under which it is presented are an aggravating circumstance if:
   a. The items and services subject to a penalty and assessment are of several types,
   b. The items and services subject to a penalty and assessment occurred over a lengthy period of time,
   c. There are many items or services (or the nature and circumstances indicate a pattern of claims for the items or services), or
   d. The total amount claimed for the items and services is $1,000 or greater.
2. Degree of culpability. The degree of culpability of a person submitting each claim or request for payment is an aggravating circumstance if:
   a. The person knew that each item or service was not provided as claimed;
   b. The person knew that no payment could be made because the person had been excluded from system reimbursement; or
   c. Payment would violate the terms of an agreement between the person and the state, the Administration or a contractor.
3. Prior offenses. The prior offenses of a person submitting each claim or request for payment is an aggravating circumstance if, at any time before the presentation of any

claim or request for payment subject to a penalty and assessment under this Article, the person was held liable for a criminal, civil, or administrative sanction in connection with:
a. A Medicaid program,
b. A Medicare program,
c. A Title XXI program, or
d. Any other public or private program of reimbursement for medical services.

4. Effect on patient care. The seriousness of an adverse effect that resulted, or could have resulted, from the failure of a person submitting a claim or request for payment to provide medically necessary care is an aggravating circumstance; or
5. Other matters as justice may require. Other circumstances of an aggravating nature shall be taken into account if, in the interest of justice, the circumstances require an increase of the penalty and assessment.

**E.** Amount of penalty and assessment. As specified in A.R.S. § 36-2993 and this Article, the aggregate amount of a penalty and assessment shall never be less than double the approximate amount of damages sustained by the state, the Administration or contractor, unless there are extraordinary mitigating circumstances.

**F.** Compromise. The Director or designee may compromise a penalty and assessment using the guidelines in subsections (C) and (D).

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

**R9-31-1103. Notice of Proposed Determination and Rights of Parties**

**A.** Administration's responsibilities. If the Director or designee proposes to impose a penalty and assessment, the Director or designee shall deliver or send by certified mail, return receipt requested, to a person, written notice of intent to impose a penalty and assessment. The notice shall include:
1. Reference to the statutory basis for the penalty and assessment,
2. A description of each claim or request for payment for which the penalty and assessment are proposed,
3. The reason why each claim or request for payment subjects the person to a penalty and assessment, and
4. The amount of the proposed penalty and assessment.

**B.** Individual's responsibilities. A person may submit within 35 days from the date of the adverse action:
1. A written statement accepting imposition of the penalty and assessment,
2. As specified in A.R.S. § 36-2993 a written request for a compromise of the penalty and assessment stating any reasons that the person contends should result in a reduction or modification of the penalty and assessment. If a request is submitted, the time period for filing an appeal and request for hearing according to subsection (C) shall be tolled until the Director's or designee's decision on the request for compromise, or
3. A grievance in accordance with the provider grievance provision in 9 A.A.C. 31, Article 8 of this Chapter.

**C.** The Director or designee may impose a proposed penalty and assessment or any less severe penalty and assessment if a person does not request a hearing within the time prescribed by subsections (B)(2) or (3). A person has no right to appeal a penalty and assessment if the person has not timely requested a hearing.

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

**R9-31-1104. Issues and Burden of Proof**

**A.** Preponderance of evidence. In any hearing conducted according to this Article, the Director or designee shall prove by a preponderance of the evidence that a person who requested a hearing presented or caused to be presented each claim or request for payment in violation of R9-31-1101. A person who requests a hearing shall bear the burden of producing and proving by a preponderance of the evidence any circumstance that would justify reducing the amount of the penalty and assessment.

**B.** Statistical sampling.
1. The Director or designee may introduce the results of a statistical sampling study as evidence of the number and amount of claims or requests for payment that were presented or caused to be presented by the person in meeting the burden of proof described in subsection (A). A statistical sampling study shall constitute prima facie evidence of the number and amount of claims or requests for payment, if based upon an appropriate sampling and computed by valid statistical methods.
2. The burden of proof shall shift to the person to produce evidence reasonably calculated to rebut the findings of the statistical sampling study once the Director or designee has made a prima facie case as described in subsection (A). The Director or designee will be given the opportunity to rebut this evidence.

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

## ARTICLE 12. BEHAVIORAL HEALTH SERVICES

**R9-31-1201. General Requirements**

General requirements. The following general requirements apply to behavioral health services provided under this Article, subject to all exclusions and limitations.
1. Administration. The program shall be administered as specified in A.R.S. § 36-2982.
2. Provision of services. Behavioral health services shall be provided as specified in A.R.S. § 36-2989 and this Chapter.
3. Definitions. The following definitions apply to this Article:
   a. "Case management services" defined in 9 A.A.C. 22, Article 12.
   b. "Health plan" means a "Contractor" as defined in A.R.S. § 36-2901.
   c. "Physician assistant" specified in A.R.S. § 32-2501. In addition, a physician assistant providing a behavioral health service shall be supervised by an AHCCCS-registered psychiatrist.
   d. "Respite" defined in 9 A.A.C. 22, Article 12.
   e. "Substance abuse" defined in 9 A.A.C. 22, Article 12.
   f. "TRBHA" means the Tribal Regional Behavioral Health Authority.
   g. "Therapeutic foster care services" defined in 9 A.A.C. 22, Article 12.

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Ses-

sion, effective October 23, 1998 (Supp. 98-4). Section repealed; new Section adopted by exempt rulemaking at 6 A.A.R. 282, effective December 16, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4740, effective October 1, 2001 (Supp. 01-3).

**R9-31-1202. ADHS and Contractor Responsibilities**

**A.** ADHS responsibilities. Behavioral health services shall be provided by a RBHA through a contract with ADHS. ADHS shall:
1. Contract with a RBHA for the provision of behavioral health services in R9-31-1205 for all Title XXI members as specified in A.R.S. § 36-2989. ADHS shall ensure that a RBHA provides behavioral health services directly to members or through subcontracts with qualified service providers who meet the qualifications specified in R9-31-1206. If behavioral health services are unavailable within a RBHA's service area, ADHS shall ensure that a RBHA provides behavioral health services outside the service area.
2. Ensure that a member's behavioral health service is provided in collaboration with a member's primary care provider.
3. Coordinate the transition of care and medical records, as specified in A.R.S. §§ 36-2986, 36-509, A.A.C. R9-31-512, and in contract, when a member transitions from:
   a. A behavioral health provider to another behavioral health provider,
   b. A RBHA to another RBHA,
   c. A RBHA to a contractor,
   d. A contractor to a RBHA, or
   e. A contractor to another contractor.

**B.** ADHS may contract with a TRBHA for the provision of behavioral health services for Native American members. In the absence of a contract with ADHS, Native American members may:
1. Receive behavioral health services from an IHS facility or a TRBHA, or
2. Be referred off-reservation to a RBHA for covered behavioral health services.

**C.** Contractor responsibilities. A contractor shall:
1. Refer a member to a RBHA according to the contract terms;
2. Provide inpatient emergency behavioral health services specified in R9-31-1205 for a member not yet enrolled with a RBHA;
3. Provide psychotropic medication services for a member, in consultation with the member's RBHA as needed, for behavioral health conditions that are specified in contract within the primary care provider's scope of practice; and
4. Coordinate a member's transition of care and medical records specified in R9-31-1202.

**D.** ADHS, its subcontractors and AHCCCS acute care contractors shall cooperate as specified in contract when a transition from one entity to another becomes necessary.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed; new Section adopted by exempt rulemaking at 6 A.A.R. 282, effective December 16, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4740, effective October 1, 2001 (Supp. 01-3).

**R9-31-1203. Eligibility for Covered Services**

**A.** Eligibility for covered services. A member determined eligible under A.R.S. § 36-2981 shall receive medically necessary covered services specified in R9-31-1205.

**B.** Ineligibility. A person is not eligible for behavioral health services if the person is:
1. An inmate of a public institution as defined in 42 CFR 435.1009;
2. A resident of an institution for the treatment of tuberculosis; or
3. In an institution for mental diseases at the time of application.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed; new Section adopted by exempt rulemaking at 6 A.A.R. 282, effective December 16, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4740, effective October 1, 2001 (Supp. 01-3).

**R9-31-1204. General Service Requirements**

**A.** Services. Behavioral health services include both mental health and substance abuse services.

**B.** Medical necessity. A service shall be medically necessary under R9-31-201.

**C.** Prior authorization. A service shall be provided by contractors, subcontractors, and providers consistent with the prior authorization requirements established by the Director and under R9-31-210 and R9-31-1205.

**D.** Experimental services. The Director shall determine if a service is experimental, or whether a service is provided primarily for the purpose of research. Those services shall not be covered.

**E.** Gratuities. A service or an item, if furnished gratuitously to a member, is not covered and payment shall be denied to a provider.

**F.** Service area. Behavioral health services rendered to a member shall be provided within the RBHA's service area except when:
1. A contractor's primary care provider refers a member to another area for medical specialty care,
2. A member's medically necessary covered service is not available within the service area, or
3. A net savings in behavioral health service delivery costs can be documented by the RBHA for a member. Undue travel time or hardship shall be considered for a member or a member's family.

**G.** Travel. If a member travels or temporarily resides out of a behavioral health service area, covered services are restricted to emergency behavioral health care, unless otherwise authorized by a member's RBHA.

**H.** Non-covered services. If a member requests a behavioral health service that is not covered by Title XXI or is not authorized by a RBHA, the behavioral health service may be provided by an AHCCCS-registered behavioral health service provider under the following conditions:
1. The requested service and the itemized cost of each service is documented and provided to the member or member's guardian; and
2. The member or member's guardian signs a statement acknowledging:
   a. Services have been explained to the member or member's guardian, and
   b. Member or member's guardian accepts responsibility for payment.

**I.** Referral. If a member is referred out of a RBHA's service area to receive an authorized medically necessary behavioral health service or a medically necessary covered service the service shall be provided by the contractor or RBHA. Behavioral health services shall be provided with the limitations specified in R9-31-1205.

**J.** Restrictions and limitations.
1. The restrictions, limitations, and exclusions in this Article shall not apply to a contractor or a RBHA when electing to provide a noncovered service.
2. Room and board is not a covered service unless provided in an inpatient, sub-acute, or residential treatment center under R9-31-1205.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed; new Section adopted by exempt rulemaking at 6 A.A.R. 282, effective December 16, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4740, effective October 1, 2001 (Supp. 01-3).

**R9-31-1205. Scope of Behavioral Health Services**

**A.** Inpatient behavioral health services. The following inpatient services shall be covered subject to the limitations and exclusions in this Article.
1. Inpatient behavioral health services provided in a Medicare (Title XVIII) certified hospital include all behavioral health services, medical detoxification, accommodations and staffing, supplies, and equipment. The behavioral health service shall be provided under the direction of a physician in:
   a. A general acute care hospital, or
   b. An inpatient psychiatric hospital.
2. Inpatient service limitations:
   a. Inpatient services, other than emergency services specified in this Section, are prior authorized.
   b. Inpatient services are reimbursed on a per diem basis and s includes all services and room and board, except the following may bill independently for services:
      i. A psychiatrist,
      ii. A certified psychiatric nurse practitioner,
      iii. A physician assistant,
      iv. A psychologist,
      v. A certified independent social worker,
      vi. A certified marriage and family therapist,
      vii. A certified professional counselor, or
      viii. A behavioral health medical practitioner under R9-31-112.
   c. A member cannot be in an IMD at the time of application or at the time of redetermination.

**B.** Level I residential treatment center services. Level I residential treatment center services under 9 A.A.C. 20, Article 2 and Article 5 are covered subject to the limitations and exclusions in this Article and:
1. Are provided under the direction of a physician in a Level I residential treatment center accredited by an AHCCCS approved accrediting body as specified in contract.
2. Are room and board and treatment services for mental health and substance abuse conditions.
3. Residential treatment center service are limited as follows:
   a. Services are prior authorized, except for emergency services as specified in this Section.
   b. Services are reimbursed on a per diem basis and are inclusive of all services, except the following may bill independently for services:
      i. A psychiatrist,
      ii. A certified psychiatric nurse practitioner,
      iii. A physician assistant,
      iv. A psychologist,
      v. A certified independent social worker,
      vi. A certified marriage and family therapist,
      vii. A certified professional counselor, or
      viii. A behavioral health medical practitioner.
   c. An applicant or member cannot be in an IMD at the time of application or at the time of redetermination.
4. The following services may be billed independently if prescribed by a provider specified in subsection (B)(3)(b)(i), (ii), (iii), and (viii):
   a. Laboratory,
   b. Radiology, and
   c. Psychotropic medication.

**C.** Level I sub-acute facility services. Level I sub-acute facility services under 9 A.A.C. 20, Article 2 and Article 5 are covered subject to the limitations and exclusions in this Article and:
1. Are provided under the direction of a physician in a Level I sub-acute facility accredited by an AHCCCS approved accrediting body as specified in contract.
2. Are room and board and treatment services for mental health and substance abuse conditions.
3. Are reimbursed on a per diem basis and are inclusive of all services, except the following may bill independently for services:
   a. A psychiatrist,
   b. A certified psychiatric nurse practitioner,
   c. A physician assistant,
   d. A psychologist,
   e. A certified independent social worker,
   f. A certified marriage and family therapist,
   g. A certified professional counselor, or
   h. A behavioral health medical practitioner.
4. An applicant or member cannot be in an IMD at the time of application or at the time of redetermination.
5. The following services may be billed independently if prescribed by a provider specified in subsection (C)(3)(a), (b), (c), and (h):
   a. Laboratory,
   b. Radiology, and
   c. Psychotropic medication.

**D.** ADHS licensed Level II behavioral health residential services. Level II behavioral health residential services under 9 A.A.C. 20, Article 2 and Article 4 are covered subject to the limitations and exclusions in this Article and:
1. Are provided by a licensed Level II agency.
2. Are inclusive of all covered services except room and board.
3. The following may bill independently for services:
   a. A psychiatrist,
   b. A certified psychiatric nurse practitioner,
   c. A physician assistant,
   d. A psychologist,
   e. A certified independent social worker,
   f. A certified marriage and family therapist,
   g. A certified professional counselor, or
   h. A behavioral health medical practitioner.

**E.** ADHS licensed Level III behavioral health residential services. Level III Behavioral Health Residential services under 9 A.A.C. 20, Article 2 and Article 4 are covered subject to the limitations and exclusions in this Article and:

1. Are provided by a licensed Level III agency.
2. Are inclusive of all covered services except room and board.
3. The following may bill independently for services:
   a. A psychiatrist,
   b. A certified psychiatric nurse practitioner,
   c. A physician assistant,
   d. A psychologist,
   e. A certified independent social worker,
   f. A certified marriage and family therapist,
   g. A certified professional counselor, or
   h. A behavioral health medical practitioner.

**F.** Partial care. Partial care services are covered subject to the limitations and exclusions in this Article.
1. Partial care service is rendered by an agency qualified to provide a regularly scheduled day program of individual member, group or family activities that are designed to improve the ability of the member to function in the community.
2. Partial care service exclusions. School attendance and educational hours are not included as a partial care service and are not billed concurrently with a partial care service.

**G.** Outpatient services. Outpatient services are covered subject to the limitations and exclusions in this Article.
1. Outpatient services shall include the following:
   a. Screening provided by a behavioral health professional or a behavioral health technician;
   b. Initial behavioral health evaluation provided by a behavioral health professional;
   c. Ongoing behavioral health evaluation by a behavioral health professional or a behavioral health technician;
   d. Counseling including individual therapy, group, and family therapy provided by a behavioral health professional or a behavioral health technician;
   e. Behavior management services provided by qualified individuals or agencies as specified in contract; and
   f. Psychosocial rehabilitation services provided by qualified individuals or agencies as specified in contract.
2. Outpatient service limitations:
   a. The following practitioners may bill independently:
      i. A psychiatrist,
      ii. A certified psychiatric nurse practitioner,
      iii. A physician assistant as defined in this Article,
      iv. A psychologist,
      v. A certified independent social worker,
      vi. A certified professional counselor,
      vii. A certified marriage and family therapist,
      viii. A behavioral health medical practitioner,
      ix. A therapeutic foster parent under 6 A.A.C. 5, Article 58, and
      x. Other AHCCCS registered providers as specified in contract.
   b. A behavioral health professional not specified in subsection (G)(2)(a) shall not bill independently unless employed by, or contracted with, an AHCCCS-registered behavioral health agency.

**H.** Behavioral health emergency services.
1. A RBHA shall ensure that behavioral health emergency services are provided by qualified personnel specified in R9-31-1206. The emergency services are available 24 hours per day, seven days per week in the RBHA's service area in emergency situations for a member who is a danger to self or others or is otherwise determined to be in need of immediate unscheduled behavioral health services. Behavioral health emergency services are provided on either an inpatient or outpatient basis.
2. A contractor shall provide behavioral health emergency services on an inpatient basis not to exceed three days per emergency episode and 12 days per contract year, for a member not yet enrolled with a RBHA.
3. An inpatient emergency service provider shall verify the eligibility and enrollment of a member through the Administration to determine the need for notification to a contractor or a RBHA and to determine the party responsible for payment of services under Article 7 of this Chapter.
4. Behavioral health emergency service limitations:
   a. An emergency behavioral health service does not require prior authorization. The provider shall, however, comply with the notification requirements under R9-31-210.
   b. A behavioral health service for an condition unrelated to the behavioral health emergency service that requires diagnosis and treatment shall be prior authorized by a RBHA.
   c. Inpatient service limitations specified in subsection (A) of this Section shall apply to emergency services provided on an inpatient basis.

**I.** Other behavioral health services.
1. Case management as under R9-31-1201;
2. Laboratory and radiology services for behavioral health diagnosis and medication management;
3. Psychotropic medication and related medication;
4. Monitoring, administration, and adjustment for psychotropic medication and related medications;
5. Respite care;
6. Therapeutic foster care; and
7. Other support services to maintain or increase the member's self-sufficiency and ability to live outside an institution.

**J.** Transportation services. The Administration shall provide transportation services under A.A.C. R9-22-211.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed; new Section adopted by exempt rulemaking at 6 A.A.R. 282, effective December 16, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4740, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4).

**R9-31-1206. General Provisions and Standards for Service Providers**

**A.** Qualified service provider. A qualified behavioral health service provider shall:
1. Be a non-contracting provider or employed by, or contracted in writing with a RBHA or a contractor to provide behavioral health services to a member;
2. Have all applicable state licenses or certifications, or comply with alternative requirements established by the Administration;
3. Register with the Administration as a service provider; and
4. Comply with all requirements under Article 5 and this Article.

**B.** Quality and Utilization management.

1. Service providers shall cooperate with the quality and utilization management programs of a RBHA, a contractor, ADHS, and the Administration which are stated in R9-31-522 and contract.
2. Service providers shall comply with applicable procedures specified in 42 CFR 456.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed; new Section adopted by exempt rulemaking at 6 A.A.R. 282, effective December 16, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4740, effective October 1, 2001 (Supp. 01-3).

**R9-31-1207. Standards for Payments**

**A.** Payment to ADHS. ADHS shall receive a monthly capitation payment, based on the number of Title XXI members at the beginning of each month. ADHS administrative costs shall be incorporated into the capitation payment.

**B.** Claims submissions.
1. ADHS shall require all contracted service providers to submit clean claims no later than the time-frame specified in the ADHS contract with the Administration.
2. A claim for emergency inpatient services for a member not yet enrolled with an RBHA shall be submitted to a contractor by a provider and shall comply with the time-frames and other applicable payment procedures in Article 7 of this Chapter.

**C.** Prior authorization. The Administration has the authority to deny payment to a provider for services or items requiring prior authorization if prior authorization is not obtained from the Administration, a RBHA, or a contractor as specified in R9-31-705.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed; new Section adopted by exempt rulemaking at 6 A.A.R. 282, effective December 16, 1999 (Supp. 99-4). Amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4).

**R9-31-1208. Grievance and Request for Hearing Process**

**A.** Processing a grievance. A grievance for an adverse action for a behavioral health service shall be processed under A.R.S. §§ 36-2986, 36-3413, 41-1092.02, and 9 A.A.C. 31, Articles 8 and 13. The grievance and request for hearing process is illustrated in 9 A.A.C. 31, Article 8, Exhibit A.

**B.** Member request for hearing. A member's request for hearing regarding a grievance under this Article shall be conducted under 9 A.A.C. 31, Article 8.

**Historical Note**

New Section adopted by exempt rulemaking at 6 A.A.R. 282, effective December 16, 1999 (Supp. 99-4). Amended by exempt rulemaking at 6 A.A.R. 3205, effective August 4, 2000 (Supp. 00-3).

## ARTICLE 13. REPEALED

*Article 13, consisting of Sections R9-31-1301 through R9-31-1309, repealed by final rulemaking at 10 A.A.R. 822, effective April 3, 2004. The subject matter of Article 13 is now in 9 A.A.C. 34 (Supp. 04-1).*

**R9-31-1301. Repealed**

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 6 A.A.R. 3205, effective August 4, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 822, effective April 3, 2004 (Supp. 04-1).

**R9-31-1302. Repealed**

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 6 A.A.R. 3205, effective August 4, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 822, effective April 3, 2004 (Supp. 04-1).

**R9-31-1303. Repealed**

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 6 A.A.R. 3205, effective August 4, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 822, effective April 3, 2004 (Supp. 04-1).

**R9-31-1304. Repealed**

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 6 A.A.R. 3205, effective August 4, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 822, effective April 3, 2004 (Supp. 04-1).

**R9-31-1305. Repealed**

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 6 A.A.R. 3205, effective August 4, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 822, effective April 3, 2004 (Supp. 04-1).

**R9-31-1306. Repealed**

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 6 A.A.R. 3205, effective August 4, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 822, effective April 3, 2004 (Supp. 04-1).

**R9-31-1307. Repealed**

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 6 A.A.R. 3205, effective August 4, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 822, effective April 3, 2004 (Supp. 04-1).

**R9-31-1308. Repealed**

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 6 A.A.R. 3205, effective August 4, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 822, effective April 3, 2004 (Supp. 04-1).

**R9-31-1309. Repealed**

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 6 A.A.R. 3205, effective August 4, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 822, effective April 3, 2004 (Supp. 04-1).

## ARTICLE 14. PREMIUMS

**R9-31-1401. Purpose**
This Article contains the requirements for the payment of a premium to the Administration by a member and the processing of a premium by the Administration.

**Historical Note**
New Section adopted by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Section repealed; new Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4).

**R9-31-1402. Premium Amount for a Member who is a Child Determined Eligible Under Article 3 of This Chapter**

**A.** For the purposes of this Article, a premium is a monthly amount that an enrolled member pays to the Administration to remain eligible for Title XXI.

**B.** When the household income is greater than 100 percent of the FPL and less than or equal to 150 percent of the FPL, the monthly premium is $10 for one eligible child and $15 for two or more eligible children.

**C.** When household income is greater than 150 percent of the FPL and less than or equal to 175 percent of the FPL, the monthly premium payment is $20 for one eligible child and $30 for two or more eligible children.

**D.** When household income is greater than 175 percent of the FPL and less than or equal to 200 percent of the FPL, the monthly premium is $25 for one eligible child and $35 for two or more eligible children.

**E.** A household's premium payments as specified in this Section shall not exceed five percent of a household's gross income.

**F.** A member's newborn is enrolled immediately upon the Administration receiving notification of the child's birth. Upon enrollment, the household's premium is redetermined.

**Historical Note**
New Section adopted by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Amended by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4). Amended by exempt rulemaking at 9 A.A.R. 4560, effective October 1, 2003 (Supp. 03-4). Amended by exempt rulemaking at 10 A.A.R. 504, effective February 1, 2004 (Supp. 04-1). Amended by exempt rulemaking at 10 A.A.R. 2887, effective July 1, 2004 (Supp. 04-2).

**R9-31-1403. Repealed**

**Historical Note**
New Section adopted by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4). Section repealed by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4).

**R9-31-1404. Hardship Exemption for a Member who is a Child Determined Eligible Under Article 3 of This Chapter**

**A.** Definitions. The following definitions apply to this Section:
1. "Major expense" means the expense is more than 10 percent of the household's countable income under R9-31-304.
2. "Medically necessary" has the same meaning as defined in A.A.C. R9-22-101.

**B.** Hardship exemption. The Administration shall provide information to the head of household regarding the request for a hardship exemption. The Administration shall grant a hardship exemption from the disenrollment requirements under A.R.S. § 36-2982 for a household who:
1. Is no longer able to pay the premium due to one of the hardship criteria in subsection (C), and
2. Submits a written request for a hardship exemption and provides all necessary written information at the time of request.

**C.** Hardship criteria. To be eligible for a hardship exemption, a household shall have:
1. Medically necessary expenses or health insurance premiums that:
   a. Are not covered under Medicaid or other insurance, and
   b. Exceed 10 percent of the household's countable income under R9-31-304;
2. Unanticipated major expense, related to maintaining a residence for the household or transportation for work;
3. A combination of medically necessary expenses under subsection (C)(1) and unanticipated major expenses under subsection (C)(2) that exceed 10 percent of the household's countable income under R9-31-304; or
4. Experienced the death of a household member during the month the premium was not paid.

**D.** Written hardship exemption request. The Administration shall not consider a hardship exemption unless the Administration receives the written request and information under subsection (C) by the due date specified in the Administration's notice that explains the undue hardship exemption requirements.

**E.** Notification. The Administration shall notify the head of household of the approval or denial of the request for exemption and discontinuance under R9-31-310, no later than 10 days from the date the Administration received the request.

**F.** Request for hearing. The head of household may request a hearing concerning the termination and denial of exemption under R9-31-803.

**Historical Note**
New Section adopted by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Former Section R9-31-1404 renumbered to R9-31-1405; new Section R9-31-1404 made by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4). Amended by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4).

**R9-31-1405. Repealed**

**Historical Note**
New Section adopted by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Former Section R9-31-1405 renumbered to R9-31-1406; new Section R9-31-1405 renumbered from R9-31-1404 and amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4). Section repealed by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4).

**R9-31-1406. Repealed**

**Historical Note**
New Section adopted by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Former Section R9-31-1406 renumbered to R9-31-1407; new Section R9-31-1406 renumbered from R9-31-1405 and amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4). Section repealed by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4).

**R9-31-1407. Repealed**

**Historical Note**
Renumbered from R9-31-1406 and amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4). Section repealed by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4).

**R9-31-1408. Premium Amount for a Member who is a Parent Determined Eligible Under Article 17 of This Chapter**

**A.** When countable income is less than or equal to 150 percent of the FPL, the monthly premium for each eligible parent is $15 per month.

**B.** When countable income is greater than 150 percent of the FPL and less than or equal to 175 percent of the FPL, the monthly premium for each eligible parent is $20 per month.

**C.** When countable income is greater than 175 percent of the FPL and less than or equal to 200 percent of the FPL, the monthly premium for each eligible parent is $25 per month.

**Historical Note**
New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4).

**R9-31-1409. Payment Due Date**
The monthly premium payment is due on the 15th day for the month of coverage.

**Historical Note**
New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4).

**R9-31-1410. Payment Received Date**
A payment is considered received on the date that the Administration receives and credits the payment to the member's account.

**Historical Note**
New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4).

**R9-31-1411. Late Payment**

**A.** Late payment date. A payment is considered late if the Administration does not receive the payment by the 15th day of the month.

**B.** Payment not received. If payment for a month is not received in full by the last working day of the month in which the payment is due, the Administration shall include the past and current due amounts in the next billing statement.

**Historical Note**
New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4).

**R9-31-1412. Payment Type**
A premium shall be paid to the Administration by a:

1. Cashier's check,
2. Personal check,
3. Money order, or
4. Form approved by the Administration.

**Historical Note**
New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4).

**R9-31-1413. Returned Check**
The Administration shall not accept a personal check when the premium has been previously paid with a personal check that was returned to the Administration because of insufficient funds.

**Historical Note**
New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4).

**R9-31-1414. Payment In Advance**
A premium may be paid in advance.

**Historical Note**
New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4).

**R9-31-1415. Payment Reimbursement**
A premium paid in advance is nonrefundable, unless the member is disenrolled at least 15 days prior to the month of coverage. A premium paid during a grievance, appeal or request for hearing under R9-31-1419 is nonrefundable.

**Historical Note**
New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4). Amended by exempt rulemaking at 9 A.A.R. 4560, effective October 1, 2003 (Supp. 03-4).

**R9-31-1416. Allocation of Payment for an Eligible Member**
Except for payments specified in R9-31-1419 of this Article, all payments received for eligible members shall first be applied to any debt owed to the Administration for a child determined eligible under Article 3 of this Chapter, and then to the debt of a parent determined eligible under Article 17 of this Chapter. Any remaining amounts shall first be applied to the next month's premium charge for the child eligible under Article 3 of this Chapter and then to the parent, eligible under Article 17 of this Chapter.

**Historical Note**
New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4).

**R9-31-1417. Premium Change**
A premium change is effective the month following the month that the change is verified and the member is timely notified of the change in the premium amount.

**Historical Note**
New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4).

**R9-31-1418. Discontinuance for Failure to Pay Premium**

**A.** Discontinuance notice. The Administration shall discontinue eligibility if the Administration does not receive the past and current due amounts by the 15th day of the month in which the Administration sends the adverse action notice. The Administration shall follow the discontinuance notice requirements under R9-31-310(B).

**B.** Discontinuance rescinded. The Administration shall continue eligibility if the past and current due amounts are received by the Administration in full, before the effective date of the discontinuance.

**C.** Discontinuance of eligibility. The Administration shall discontinue eligibility on the effective date of the discontinuance if the past and current due amounts are not received by the Administration in full, before the effective date of the discontinuance.

**D.** Payment of premium. A member who was discontinued for an unpaid premium shall pay the past due premium amounts to the Administration before eligibility under this Article can be reestablished.

**Historical Note**
New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4).

**R9-31-1419. Premium During the Grievance and Request for Hearing Process**

**A.** Continued coverage. To receive continued coverage from the time a request for hearing is filed for a discontinuance of eligibility, and a final decision is made, a member shall:
1. Pay a one month premium to the Administration before the effective date of the discontinuance, and
2. Continue to pay the premium by the 15th day of each month during the hearing process.

**B.** Method of payment. To continue coverage in subsection (A) a member shall pay the premium by:
1. Cashier's check,
2. Money order, or
3. Form approved by the Administration.

**C.** Decision upheld. If the decision to discontinue is upheld, the Administration shall apply any remaining premium amount to the administrative cost of the hearing process.

**D.** Decision overturned. If the decision to discontinue is overturned, the Administration shall apply any remaining premium amount to the next month's premium charge.

**Historical Note**
New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4).

## ARTICLE 15. RESERVED

## ARTICLE 16. SERVICES FOR NATIVE AMERICANS

**R9-31-1601. General Requirements**

**A.** A Native American who is a member may receive:
1. Covered acute care services specified in this Chapter from:
   a. An IHS area office under A.R.S. § 36-2982 that has a signed IGA with the Administration,
   b. A Tribal Facility under A.R.S. § 36-2982, or
   c. A contractor under A.R.S. § 36-2901.
2. Covered behavioral health care services as specified in this Chapter from:
   a. An IHS area office under A.R.S. § 36-2982 that has a signed IGA with the Administration,
   b. A Tribal Facility under A.R.S. § 36-2982, or
   c. A RBHA or TRBHA.

**B.** In providing covered services to a member, IHS and a Tribal Facility shall comply with:
1. Federal and state law;
2. The IGA, if applicable; and
3. This Chapter as applicable.

**C.** An individual or an entity that provides covered services for the IHS or a Tribal Facility shall be an AHCCCS registered provider.

**D.** The IHS and a Tribal Facility under 42 CFR 431.110 shall meet state requirements as a Medicaid provider. Medical records shall:
1. Conform to 9 A.A.C. 20 for documentation of medical, diagnostic and treatment data;
2. Include a detailed record of:
   a. All medically necessary services provided to a member by the IHS or a Tribal Facility,
   b. All emergency services provided by a provider or a noncontracting provider for a member enrolled with the IHS or receiving services from a Tribal Facility,
   c. All covered services provided through a referral to a facility or provider outside the IHS or Tribal facility network, and
3. Facilitate follow-up treatment.

**E.** As specified in A.R.S. §§ 36-2986 and 36-2992, the IHS or a Tribal Facility shall advise the Director or designee immediately, in writing, of any case of suspected fraud or abuse.

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4).

**R9-31-1602. General Requirements for Scope of Services**

**A.** In addition to the requirements and the limitations specified in this Chapter, the following general requirements apply:
1. Under A.R.S. § 36-2989, covered services provided to a member shall be medically necessary and provided by, or under the direction of, the IHS, a Tribal Facility, a provider, or a dentist. Specialist services are provided under referral from the IHS or a Tribal Facility provider.
2. If IHS cannot provide a covered service due to in the appropriation of funds by Congress, the obligation to allocate IHS program resources nationwide, or a fundamental shift in the manner of providing health services to Native Americans on a national basis then a member shall be referred to a non IHS provider or a non IHS facility for the service.

**B.** As specified in A.R.S. § 36-2989, covered services rendered to a member are provided within the service area of the IHS or a Tribal Facility except when:
1. An IHS or a Tribal Facility refers a member out of the area for medical specialty care or behavioral health services,
2. A covered service that is medically necessary for a member is not available within the service area, or
3. A member is placed in an NF located out of the service area.

**C.** If a member requests the provision of service that is not covered or not authorized by the IHS or Tribal Facility, an AHCCCS registered provider may provide the service under the following conditions:
1. IHS or a Tribal Facility shall prepare and provide the member with a document that lists the requested services and the estimated cost of each service; and
2. The member signs a document prior to the provision of services indicating that the member understands the services and accepts the responsibility for payment.

**D.** Noncovered services provided to a member by the IHS, a Tribal Facility or under referral may be paid by the IHS or a Tribal Facility, but not with Title XXI funds.

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Ses-

sion, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4).

**R9-31-1603. Inpatient General Hospital Services**

**A.** A fee-for-service provider or non-contracting provider shall provide the following inpatient general hospital services including:
1. Hospital accommodations and appropriate staffing, supplies, equipment, and services for:
   a. Maternity care, including labor, delivery, and recovery room, birthing center, and newborn nursery;
   b. Neonatal intensive care (NICU);
   c. Intensive care (ICU);
   d. Surgery, including surgery room and recovery room;
   e. Nursery;
   f. Routine care; and
   g. Emergency behavioral services under 9 A.A.C. 31, Article 12;
2. The following ancillary services including:
   a. Laboratory services;
   b. Radiological and medical imaging services;
   c. Anesthesiology services;
   d. Rehabilitation services;
   e. Pharmaceutical services and prescription drugs;
   f. Respiratory therapy;
   g. Blood and blood derivatives; and
   h. Central supply items, appliances, and equipment that are not ordinarily furnished to all patients which are customarily reimbursed as ancillary services.

**B.** The following limitations apply to inpatient general hospital services that are provided by a FFS provider:
1. A provider shall obtain prior authorization from the Administration for the following inpatient hospital services:
   a. Nonemergency and elective admission, including psychiatric hospitalization;
   b. Elective surgery, excluding a voluntary sterilization procedure. A voluntary sterilization procedure does not require prior authorization; and
   c. A service or items provided to reconstruct or improve personal appearance after an illness or injury.
2. The Administration may perform concurrent review for hospitalizations to determine whether there is medical necessity for the hospitalization.
   a. A provider shall notify the Administration no later than the fourth day of hospitalization after an emergency admission or no later than the second day after an intensive care unit admission so that the Administration may initiate concurrent review of the hospitalization.
   b. Failure of the provider to obtain prior authorization is cause for denial of a claim.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 2365, effective May 9, 2002 (Supp. 02-2).

**R9-31-1604. Physician and Primary Care Physician and Practitioner Services**

**A.** Primary care services shall be furnished by a physician or a primary care practitioner. Primary care services may be provided in an inpatient or outpatient setting and shall include:
1. Periodic health examinations and assessments,
2. Evaluations and diagnostic workups,
3. Prescriptions for medications and medically necessary supplies and equipment,
4. Referrals to a specialist or other health care professional when medically necessary as specified in A.R.S. § 36-2989,
5. Patient education,
6. Home visits when determined medically necessary,
7. Covered immunizations, and
8. Covered preventive health services.

**B.** As specified in A.R.S. § 36-2989, a second opinion procedure may be required to determine coverage for surgeries for a member referred out of the IHS or a Tribal Facility. Under this procedure, documentation must be provided by at least two physicians as to the need for the proposed surgery.

**C.** The following limitations and exclusions apply to physician and practitioner services and primary care provider services for a member referred out of the IHS or a Tribal Facility:
1. Specialty care and other services provided to a member upon referral from a primary care provider shall be limited to the services or conditions for which the referral is made, or for which authorization is given;
2. If a physical examination is performed with the primary intent to accomplish one or more of the objectives listed in subsection (A), it may be covered by the IHS or a Tribal Facility except if there is an additional or alternative objective to satisfy the demands of an outside public or private agency. Alternative objectives may include physical examinations and resulting documentation for:
   a. Qualification for insurance,
   b. Pre-employment physical evaluation,
   c. Qualification for sports or physical exercise activities,
   d. Pilot's examination (FAA),
   e. Disability certification for establishing any kind of periodic payments,
   f. Evaluation for establishing third-party liabilities, or
   g. Physical ability to perform functions that have no relationship to primary objectives listed in subsection (A).
3. The following services shall be excluded from Title XXI coverage:
   a. Infertility services, reversal of surgically induced infertility (sterilization), and sex change operations;
   b. Services or items furnished solely for cosmetic purposes;
   c. Hysterectomies, unless determined to be medically necessary;
   d. Abortion counseling or abortion except according to federal law;
   e. Chiropractic services; and
   f. Licensed midwife service for prenatal care and home births.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Subsection labeling in subsection (A) amended to correct manifest typographical error (Supp. 01-3).

**R9-31-1605. Organ and Tissue Transplantation Services**

**A.** The following organ and tissue transplantation services are covered for a member as specified in A.R.S. § 36-2989 if prior authorized by the Administration:
1. Kidney transplantation,
2. Simultaneous Kidney/Pancreas transplant,
3. Cornea transplantation,
4. Heart transplantation,
5. Liver transplantation,
6. Autologous and allogenic bone marrow transplantation,
7. Lung transplantation,
8. Heart-lung transplantation, and
9. Other organ transplantation if the transplantation is required by federal law and if other statutory criteria are met.

**B.** Immunosuppressant medications, chemotherapy, and other related services provided in an IHS, a Tribal Facility, or by a referral provider do not need to be prior authorized.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

**R9-31-1606. Dental Services**

Medically necessary dental services shall be provided for children under age 19 as specified in A.R.S. § 36-2989.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

**R9-31-1607. Laboratory, Radiology, and Medical Imaging Services**

As specified in A.R.S. § 36-2989, laboratory, radiology, and medical imaging services may be covered services if:
1. Prescribed for a member by an IHS, a Tribal Facility care provider or a dentist, or if prescribed by a physician or a practitioner upon referral from the IHS, a Tribal Facility provider or a dentist;
2. Provided in a hospital, a clinic, a physician office, or other health care facility by IHS or a Tribal Facility provider; or
3. Provided by an IHS or a Tribal Facility provider that meets all applicable state and federal license and certification requirements and provides only services that are within the scope of practice stated in a provider's license or certification.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

**R9-31-1608. Pharmaceutical Services**

**A.** Pharmaceutical services may be provided by the IHS, a Tribal Facility, or upon referral from an IHS or a Tribal Facility provider.

**B.** As specified in A.R.S. § 36-2989, pharmaceutical services are covered if prescribed for a member by the IHS, a Tribal Facility provider or a dentist, or if prescribed by a specialist upon referral from the IHS or a Tribal Facility provider.

**C.** The following limitations apply to pharmaceutical services:
1. A medication personally dispensed by a physician or a dentist, or a practitioner within the individual's scope of practice, is not covered, except in geographically remote areas where there is no participating pharmacy or if accessible pharmacies are closed.
2. A prescription or refill in excess of 100-unit doses is not covered. A prescription or refill in excess of a 30-day supply is not covered unless specified in subsection (C)(3).
3. A prescription or refill in excess of a 30-day supply is covered if:
   a. The medication is prescribed for a chronic illness and the prescription is limited to no more than a 100-day supply or 100-unit doses, whichever is greater.
   b. The member will be out of the provider's service area for an extended period of time and the prescription is limited to the extended time period, not to exceed a 100-day supply or 100-unit doses, whichever is greater.
   c. The medication is prescribed for contraception and the prescription is limited to no more than a 100-day supply.
4. An over-the-counter medication in place of a covered prescription medication is covered only if the over-the-counter medication is appropriate, equally effective, safe, and is less costly than the covered prescription medication.

**D.** The IHS or a Tribal Facility shall monitor and ensure sufficient services to prevent any gap in the pharmaceutical regimen of a member who requires a continuing or complex regimen of pharmaceutical treatment to restore, improve, or maintain physical well-being.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 2365, effective May 9, 2002 (Supp. 02-2).

**R9-31-1609. Emergency Services**

Emergency medical services provided by the IHS, a Tribal Facility, or a referral provider outside the service area shall be provided based on the prudent layperson standard to a member by the IHS or a Tribal Facility provider registered with AHCCCS to provide services as specified in A.R.S. § 36-2989.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

**R9-31-1610. Transportation Services**

The Administration shall provide transportation services under A.A.C. R9-22-211.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4).

**R9-31-1611. Medical Supplies, Durable Medical Equipment, and Orthotic and Prosthetic Devices**

**A.** Medical supplies, DME, and orthotic and prosthetic devices are covered services if provided in compliance with the requirements of this Chapter; and
1. Authorized by the Administration,
2. Prescribed by the IHS or Tribal Facility provider, or
3. Prescribed by a physician or a practitioner upon referral from the IHS or a Tribal Facility unless the referral is waived by the Administration.

**B.** Covered medical supplies are consumable items that are disposable and are essential to a member's health.

**C.** Covered DME is any item, appliance, or piece of equipment that is:
1. Designed for a medical purpose,
2. To withstand wear,
3. Generally reusable by others, and
4. Purchased or rented for a member.

**D.** Covered prosthetic and orthotic devices are only those items that are essential for the habilitation or rehabilitation of a member.

**E.** The following limitations on coverage apply:
1. DME is furnished on a rental or purchase basis, whichever is less expensive. The total expense of renting the DME does not exceed the cost of the DME if purchased.
2. Reasonable repair or adjustment of purchased DME is covered if necessary to make the DME serviceable and if the cost of repair is less than the cost of renting or purchasing another unit.
3. A change in, or addition to, an original order for DME is covered if approved by a member's IHS or a Tribal Facility provider or an authorized prescriber and the change or addition is indicated clearly on the order and initialed by a vendor.
4. Reimbursement for rental fees shall terminate:
   a. No later than the end of the month in which the IHS or a Tribal Facility provider or an authorized prescriber certifies that the member no longer needs the DME,
   b. If the member is no longer eligible for service through this program, or
   c. If the member is no longer enrolled with the IHS with the exception of transitions of care as specified by the Administration.
5. Personal incidentals including items for personal cleanliness, body hygiene, and grooming are not covered unless needed to treat a medical condition and:
   a. Prescribed by:
      i. The member's attending physician or practitioner, or
      ii. A specialist upon referral from an IHS or tribal facility provider, and
   b. Authorized as required by the Administration.
6. First aid supplies are not covered unless they are provided according to a prescription.

**F.** Liability and ownership.
1. Purchased DME provided to a member that is no longer needed may be disposed of as specified in the policy of the IHS or a Tribal Facility.
2. If customized DME is purchased for a member by the Administration, the DME shall remain with the member during times of transition, or upon loss of eligibility.
   a. For purposes of this Section, customized DME refers to DME that has been altered or built to specifications unique to a member's medical needs and that, most likely, cannot be used or reused to meet the needs of another individual.
   b. A member shall return customized equipment obtained fraudulently to the Administration.

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 2365, effective May 9, 2002 (Supp. 02-2).

**R9-31-1612. Health Risk Assessment and Screening Services**

**A.** As specified in A.R.S. § 36-2989, the following services shall be covered for a member less than 19 years of age:
1. Screening services, including:
   a. Comprehensive health, behavioral health, and developmental histories;
   b. Comprehensive unclothed physical examination;
   c. Appropriate immunizations according to age and health history;
   d. Health education, including anticipatory guidance; and
   e. Laboratory tests.
2. Vision services including:
   a. Diagnosis and treatment for defects in vision.
   b. Eye examinations for the provision of prescriptive lenses, and
   c. Provision of prescriptive lenses.
3. Hearing services, including:
   a. Diagnosis and treatment for defects in hearing,
   b. Testing to determine hearing impairment, and
   c. Provision of hearing aids.

**B.** Providers of services shall meet the following standards:
1. Provide services by or under the direction of a member's IHS or a Tribal Facility provider or a dentist;
2. Perform tests and examinations under 42 CFR 441, Subpart B, January 29, 1985, which is incorporated by reference and on file with the Office of the Secretary of State and the Administration. This incorporation by reference contains no future editions or amendments;
3. Refer a member as necessary for dental diagnosis and treatment, and necessary specialty care; and
4. Refer a member as necessary for behavioral health evaluation and treatment services as specified in this Article.

**C.** The IHS or a Tribal Facility shall meet additional conditions for a member as stated in the Intergovernmental Agreement between the Administration and IHS.

**D.** The IHS or a Tribal Facility provider shall refer a member with special health care needs under A.A.C. R9-7-301 to CRS.

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 2365, effective May 9, 2002 (Supp. 02-2).

**R9-31-1613. Other Medical Professional Services**

**A.** The following medical professional services are covered services if a member receives these services in an inpatient, an outpatient, or an office setting as follows:
1. Dialysis;
2. The following family planning services if provided to delay or prevent pregnancy:
   a. Medications,
   b. Supplies,
   c. Devices, and
   d. Surgical procedures.
3. Family planning services are limited to:
   a. Contraceptive counseling, medication, supplies, and associated medical and laboratory examinations, including HIV blood screening as part of a package of sexually transmitted disease tests provided with a family planning service; and
   b. Natural family planning education or referral;
4. Midwife services provided by a certified nurse practitioner;

5. Podiatry services if ordered by an IHS or a Tribal Facility provider;
6. Respiratory therapy;
7. Ambulatory and outpatient surgery facilities services;
8. Home health services;
9. Private or special duty nursing services if medically necessary and prior authorized;
10. Rehabilitation services including physical therapy, occupational therapy, speech therapy, and audiology provided under this Article;
11. Total parenteral nutrition services which is the provision of total caloric needs by intravenous route for individuals with severe pathology of the alimentary tract;
12. Hospice care under R9-22-213,
13. Inpatient chemotherapy, and
14. Outpatient chemotherapy.

**B.** The Administration shall prior authorize services in subsections (A)(4) through (12) for a member referred out of the IHS or a Tribal Facility service area.

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 2365, effective May 9, 2002 (Supp. 02-2).

**R9-31-1614. NF, Alternative HCBS Setting, or HCBS**

**A.** Services provided in a NF including room and board, alternative HCBS setting, or HCBS as defined in R9-28-101 are covered for a maximum of 90 days per contract year if the member's medical condition would otherwise require hospitalization.

**B.** Except as otherwise provided in 9 A.A.C. 28, the following services are not itemized for separate billing if provided in a NF, alternative HCBS setting, or HCBS:
1. Nursing services including:
   a. Administration of medication,
   b. Tube feeding,
   c. Personal care service (assistance with bathing and grooming),
   d. Routine testing of vital signs, and
   e. Maintenance of catheter.
2. Basic patient care equipment and sickroom supplies, including:
   a. First aid supplies such as bandages, tape, ointment, peroxide, alcohol, and over the counter remedies;
   b. Bathing and grooming supplies;
   c. Identification device;
   d. Skin lotion;
   e. Medication cup;
   f. Alcohol wipes, cotton balls, and cotton rolls;
   g. Rubber gloves (non-sterile);
   h. Laxatives;
   i. Bed and accessories;
   j. Thermometer;
   k. Ice bag;
   l. Rubber sheeting;
   m. Passive restraints;
   n. Glycerin swabs;
   o. Facial tissue;
   p. Enemas;
   q. Heating pad; and
   r. Diapers.
3. Dietary services including preparing and administering special diets or adaptive tools for eating;
4. Any service that is included in a NF's room and board charge or a service that is required of the NF to meet a federal mandate, state licensure standard, or county certification requirement;
5. Physical therapy; and
6. Assistive device or non-customized DME.

**C.** The Administration shall prior authorize each NF admission outside the IHS or a Tribal Facility's service area.

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Amended by final rulemaking at 8 A.A.R. 2365, effective May 9, 2002 (Supp. 02-2).

**R9-31-1615. Eligibility and Enrollment**

The eligibility and enrollment provisions specified in 9 A.A.C. 31, Article 3 apply to a Native American who elects to receive services through the IHS or a Tribal Facility.

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

**R9-31-1616. Standards for Payments**

**A.** The Administration shall bear no liability for providing covered services to or completing a plan of treatment for any member beyond the date of termination of a member's eligibility or enrollment as specified in A.R.S. § 36-2987.

**B.** The Administration shall make payments to the IHS, a Tribal Facility, or under referral from an IHS or a Tribal Facility provider based on the Administration's capped fee schedule as specified in A.A.C. R9-22-710 for outpatient services.

**C.** The Administration shall make payments to the IHS or a Tribal Facility based on the all inclusive inpatient rates published in the *Federal Register*.

**D.** The Administration shall pay inpatient and outpatient hospital services provided by a provider under referral from the IHS or a Tribal Facility provider based on A.R.S. §§ 36-2987, 36-2904, 36-2903.01, and A.A.C. R9-22-712 and R9-22-718, as applicable. Discounts and penalties shall be as specified in A.R.S. § 36-2987(C).

**E.** The Administration shall bear no liability for a subcontract that the IHS or a Tribal Facility executes with other parties for the provision of administrative or management services, medical services, or covered health care services, or for any other purpose. The IHS or a Tribal Facility shall indemnify and hold the Administration harmless from any and all liability arising from the IHS or a Tribal Facility's subcontracts, shall bear all costs of defense of any litigation over the liability, and shall satisfy in full any judgment entered against the Administration in litigation involving the IHS or a Tribal Facility's subcontracts.

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

**R9-31-1617. Prior Authorization**

A provider and a noncontracting provider shall request prior authorization from the Administration according to this Article.

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Ses-

sion, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 2365, effective May 9, 2002 (Supp. 02-2).

**R9-31-1618. Claims Submission to the Administration**

**A.** Timely Submission of Claims.
1. Under A.R.S. § 36-2904(H)(3), the Administration regards a paper or electronic claim as submitted on the date that it is received by the Administration. The Administration shall do one or more of the following for each claim it receives:
   a. Place a date stamp on the face of the claim,
   b. Assign a system-generated claim reference number, or
   c. Assign a system-generated date-specific number.
2. Except as provided in subsection (A)(6), the IHS, a Tribal Facility, or a provider under referral shall initially submit a claim for covered services to the Administration not later than:
   a. Six months from the date of service; or
   b. Six months from the date of eligibility posting, whichever is later.
3. The Administration shall deny the claim if the claim is not initially submitted within:
   a. The six-month period from the date of service; or
   b. Six months from the date of eligibility posting, whichever is later.
4. Except as provided in subsection (A)(6), if the IHS, a Tribal Facility, or a provider under referral submits an initial claim within the six-month period noted in subsection (A)(2), the IHS, Tribal Facility, or provider shall submit a clean claim to the Administration not later than:
   a. 12 months from the date of service; or
   b. 12 months from the date of eligibility posting, whichever is later.
5. The claim is clean when it meets the requirements under A.R.S. § 36-2904(H).
6. Under A.R.S. § 36-2987, the IHS, a Tribal Facility, or a provider under referral shall:
   a. Initially submit a claim for inpatient hospital services not later than six months from the date of member discharge for each claim, and
   b. Submit a clean claim for inpatient hospital services not later than 12 months from the date of discharge for each claim.

**B.** Claims Processing
1. The Administration shall notify the IHS, a Tribal Facility, or a provider under referral with a remittance advice when a claim is processed for payment.
2. The Administration shall pay valid clean claims in a timely manner according to 42 CFR 447.45, February 15, 1990, which is incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.
   a. 90 percent of valid clean claims shall be paid within 30 days of the date of receipt of the claim;
   b. 99 percent of valid clean claims shall be paid within 90 days of the date of receipt of the claim; and
   c. The remaining one percent of valid clean claims shall be paid within 12 months of the date of receipt of a claim.
3. A claim is paid on the date indicated on the disbursement check.
4. A claim is denied as of the date of the remittance advice.
5. The Administration shall process a hospital claim according to R9-22-712.

**C.** Overpayments for Title XXI Services.
1. The IHS, a Tribal Facility, or a provider under referral shall notify the Administration when the provider discovers an overpayment was made by the Administration.
2. The Administration shall recoup an overpayment from a future claim cycle if the IHS, a Tribal Facility, or a provider under referral fails to return the incorrect payment amount to the Administration.

**D.** Postpayment Claims Review.
1. The Administration shall conduct postpayment review of claims paid by the Administration if monies have been erroneously paid to the IHS, a Tribal Facility, or a provider under referral.
2. The Administration shall recoup an overpayment from a future claim cycle if the IHS, a Tribal Facility, or a provider under referral fails to return the incorrect payment amount to the Administration.
3. The Administration shall document any recoupment of an overpayment on a remittance advice.
4. The IHS, a Tribal Facility, or a provider under referral may file a grievance or request for hearing under Article 8 of this Chapter if the AHCCCS registered provider disagrees with the recoupment action.

**E.** Claims Review
1. The IHS, a Tribal Facility, or a provider under referral shall:
   a. Obtain prior authorization from the Administration for non-emergency hospital admissions and covered services as specified in Articles 2 and 12 of this Chapter,
   b. Notify the Administration of hospital admissions under Article 2, and
   c. Make records available for review by the Administration.
2. The Administration shall reduce payment of or deny a claim if the IHS, Tribal Facility, or a provider under referral fails to obtain prior authorization or to notify the Administration under Article 2 and this Article.
3. The Administration may conduct prepayment medical review and post-payment review on all hospital claims, including outlier claims.
4. If the Administration issues prior authorization for a specific level of care but subsequent medical review indicates that a different level of care was medically appropriate, the claim shall be paid, or adjusted to pay, for the cost of the appropriate level of care.
5. Post-payment reviews shall comply with A.R.S. § 36-2987.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4). Amended by final rulemaking at 8 A.A.R. 3350, effective July 15, 2002 (Supp. 02-3).

**R9-31-1619. Hospital Claims Review**

The IHS and a Tribal Facility shall follow the procedures for a hospital claims review as specified in A.A.C. R9-22-717.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

**R9-31-1620. Prohibitions Against Charges to Members**

**A.** Except as provided in subsection (B), the IHS, a Tribal Facility, or a provider under referral, shall not do either of the following, unless services are not covered or without first receiving verification from the Administration that the person was ineligible for AHCCCS on the date of service:
1. Charge, submit a claim to, demand or collect payment from a person claiming to be AHCCCS eligible; or
2. Refer or report a person claiming to be AHCCCS eligible to a collection agency or credit reporting agency.

**B.** The IHS, a Tribal Facility, or a provider under referral may charge, submit a claim to, demand or collect payment from a member as follows:
1. To collect an authorized copayment;
2. To pay for non-covered services;
3. To recover from a member that portion of a payment made by a third-party to the member if the payment duplicates AHCCCS paid benefits and is not assigned to a contractor. An AHCCCS registered provider that makes a claim under this Article shall not charge more than the actual, reasonable cost of providing the covered service; or
4. To bill a member for medical expenses incurred during a period when the member intentionally withheld information or intentionally provided inaccurate information pertaining to the member's AHCCCS eligibility or enrollment that caused the payment to the provider to be reduced or denied.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 3350, effective July 15, 2002 (Supp. 02-3).

**R9-31-1621. Transfer of Payments**

**A.** Business agent. For purposes of this Section, a business agent is a firm such as a billing service or accounting firm that renders statements and receives payment in the name of the contractor or AHCCCS registered provider.

**B.** Allowable transfer of payments. The Administration may make payments to other than the IHS, a Tribal Facility, or a provider under referral after considering whether:
1. There is an assignment to a government agency or there is an assignment under a court order; or
2. A business agent's compensation is:
   a. Related to the cost of processing the statements; and
   b. Not dependent upon the actual collection of payment.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 3350, effective July 15, 2002 (Supp. 02-3).

**R9-31-1622. The Administration's Liability to Hospitals for the Provision of Emergency and Subsequent Care**

**A.** Expenses for an emergency or acute medical health condition of a member are reimbursed only until the member's condition is stabilized and the member is transferable, or until the member is discharged following stabilization subject to the requirements of this Chapter and A.R.S. § 36-2989. This Section only applies to those noncontracting hospitals outside the IHS or Tribal Facility network.

**B.** Subject to subsection (A), if a member cannot be transferred following stabilization to the IHS or a Tribal Facility, the Administration shall pay for all appropriately documented, prior authorized, and medically necessary treatment provided to a member before the discharge date or transfer under R9-31-705.

**C.** If a member refuses transfer from a noncontracting provider or a noncontracting hospital to the IHS or a Tribal Facility, the Administration is not liable for any costs incurred after the date of refusal if:
1. After consultation with a member's IHS or a Tribal Facility, a member continues to refuse the transfer; and
2. A member is provided and signs a written statement, before the date the member is liable for payment informing a member of the medical and financial consequences of refusing to transfer. If a member refuses to sign a written statement, a statement signed by two witnesses indicating that the member was informed may be substituted.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4).

**R9-31-1623. Repealed**

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Section repealed by final rulemaking at 8 A.A.R. 3350, effective July 15, 2002 (Supp. 02-3).

**R9-31-1624. Specialty Contracts**

The Director may at any time negotiate or contract for specialized hospital and medical services including, but not limited to, transplants, neonatology, neurology, cardiology, and burn care. Specialty contractors shall take precedence over all other contractual arrangements between the IHS or a Tribal Facility. If the Administration and a hospital perform a transplant surgery on a member that does not have a contracted rate, the system shall not reimburse a hospital more than the contracted rate established by the Administration.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

**R9-31-1625. Behavioral Health Services**

**A.** The IHS, a TRBHA, a RBHA or a Tribal Facility may provide any or all of the behavioral health services specified in 9 A.A.C. 31, Article 12, subject to the limitations and specifications stated in 9 A.A.C. 31, Article 12, to a Native American who is a member.

**B.** The IHS, a Tribal Facility, a contractor, a TRBHA or a RBHA shall cooperate as specified in contract, IGA, or this Chapter when the transition from one entity to another becomes necessary.

**C.** The IHS and a Tribal Facility shall be considered a provider for the provision of behavioral health services and shall be subject to the requirements of:
1. A TRBHA if one is operating in a service area, or
2. A RBHA in a service area that does not have a TRBHA or a contractor for a Native American member with respect to prior authorization and service authorizations.

**D.** If either the IHS or a Tribal Facility cannot provide a nonemergency inpatient or an outpatient behavioral health service, the IHS or a Tribal Facility shall refer the member to a RBHA or a TRBHA.

**E.** If a member is enrolled with a contractor and is not enrolled with a TRBHA or a RBHA, the contractor is responsible for the provision of emergency behavioral health services for up to three days per admission, not to exceed 12 days per contract year, and shall refer a member to a TRBHA or a RBHA for continued service authorization and any needed additional services.

**F.** The provider shall obtain prior authorization for all inpatient hospitalizations and partial care services as authorized in R9-31-1202 and R9-31-1203.

**G.** A provider shall comply with the requirements specified in subsections (B) and (C). If a provider fails to comply, payment is denied, or if paid, is recouped by the Administration.

**H.** A behavioral health service provided by the IHS or a Tribal Facility shall be reimbursed as specified in R9-31-1616.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4).

## ARTICLE 17. ELIGIBILITY AND ENROLLMENT FOR A PARENT

*Article 17, consisting of Sections R9-31-1701 through R9-31-1724, made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4).*

### R9-31-1701. General

**A.** Purpose. This Article contains the criteria to determine the eligibility and enrollment of a parent under A.R.S. §§ 36-2981.01, 36-2982, and 36-2983. Unless otherwise noted in this Chapter, the provisions of this Chapter apply to a parent eligible under this Article.

**B.** Expenditure limit and enrollment

1. Eligibility of a parent shall be based on the FPL established in A.R.S. § 36-2981.01, subject to the availability of monies. If the Director determines that monies are insufficient for the program, the eligibility agency shall suspend accepting new applications and shall deny all pending applications.
2. If the federal government eliminates federal funding for the program, the eligibility agency shall deny all pending applications and shall discontinue an eligible parent after providing advance notice that the program shall terminate under A.R.S. § 36-2985.
3. A parent is not entitled to a hearing under R9-31-1724 of this Article, if the program is suspended or terminated.

**C.** Definition

1. For the purposes of this Article, a child is:
   a. A child, except for a deemed newborn, under A.R.S. § 36-2901(6)(a)(ii), who is determined eligible under 9 A.A.C. 22, Article 14, or
   b. A child, except for a deemed newborn, under A.R.S § 36-2981(6) who is determined eligible under Article 3 of this Chapter. A child in the guaranteed enrollment period under R9-31-307 or a newborn under R9-31-309, is not considered a child under this Article.
2. For the purposes of this Article, a parent is defined under A.R.S. § 36-2981.01 and also includes a stepparent. A parent of an 18 year old child under subsection (C)(1)(a) is not eligible under this Article.
3. For the purposes of this Article, eligibility agency means either DES or the Administration, whichever agency made the eligibility determination for the child.

**D.** Services. A parent eligible under this Article shall receive medically necessary services under 9 A.A.C. 22, Article 2.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4).

### R9-31-1702. Application

**A.** Application form. A parent who wants to apply for eligibility under this Article shall apply using an application approved by the Administration.

**B.** Application process. For a parent of a child under R9-31-1701(C)(1)(a), the Administration shall process an application under A.A.C. R9-22-1405(A) through (F), R9-22-1411(A) and (C), and R9-22-1407. For a parent of a child under R9-31-1701(C)(1)(b), the Administration shall process an application under R9-31-302(A) through (E).

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 9 A.A.R. 5150, effective January 3, 2004 (Supp. 03-4).

### R9-31-1703. Parent Eligibility Criteria

To be eligible, a parent shall be a parent of, and living with, a child as defined in R9-31-1701(C).

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4).

### R9-31-1704. Income

To be eligible, the countable income shall be determined under R9-31-304 and shall not exceed the percentage of FPL established in A.R.S. § 36-2981.01. For a parent of a child under R9-31-1701 (C)(1)(a), the countable income shall include a stepparent's income if the stepparent is applying.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4).

### R9-31-1705. Citizenship

To be eligible, a parent shall be a United States citizen or a qualified alien as specified in A.R.S. § 36-2903.03(B).

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4).

### R9-31-1706. Residency

To be eligible, a parent shall be a current resident of the State of Arizona.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4).

### R9-31-1707. Social Security Number (SSN)

To be eligible, a parent shall provide a SSN or apply for a SSN within 30 days after submitting an application.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4).

**R9-31-1708. Age**
To be eligible, a parent shall be age 19 or older.

**Historical Note**
New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4).

**R9-31-1709. Ineligibility for Title XIX**
To be eligible, a parent shall not be eligible for Title XIX under A.R.S. § 36-2901(6). A parent is not eligible under this Article if ineligibility for Title XIX is due to the parent's refusal to apply for Title XIX or the parent's noncompliance with a Title XIX eligibility requirement.

**Historical Note**
New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4).

**R9-31-1710. Institutionalized Person**
To be eligible, a parent shall not be an inmate of a public institution or a patient in an IMD under A.R.S. § 36-2983(G), unless federal financial participation is available.

**Historical Note**
New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4).

**R9-31-1711. Other Health Coverage**
To be eligible, a parent shall not be covered under an employer's group health insurance plan, family or individual health insurance, or other health insurance, including Medicare. Eligibility for the Indian Health Service is not considered other health coverage.

**Historical Note**
New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4).

**R9-31-1712. State Health Benefits**
To be eligible, a parent shall not be eligible for health coverage under a state health benefit plan based on a family member's employment with a public agency in the State of Arizona.

**Historical Note**
New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4).

**R9-31-1713. Prior Health Insurance Coverage**
To be eligible, a parent shall not have been covered by health insurance as defined in R9-31-1711 or R9-31-1712 of this Article, during the previous three months, unless that health insurance was discontinued due to the involuntary loss of employment or other involuntary reason.

**Historical Note**
New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4).

**R9-31-1714. Premium**
To be eligible, a parent shall pay the premium amount under Article 14 of this Chapter. A Native American parent is exempt from paying a premium.

**Historical Note**
New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4).

**R9-31-1715. Non-payment of Premium**
Prior to becoming eligible, a parent shall be required to pay all unpaid premiums for the:
1. Parent,
2. Parent's children, and
3. Parent's spouse with whom the parent resides, and with whom the parent resided at the time the premium was incurred.

**Historical Note**
New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4). Amended by exempt rulemaking at 9 A.A.R. 730, effective March 1, 2003 (Supp. 03-1).

**R9-31-1716. Verification**
To be eligible, a parent shall provide verification or authorize the release of verification for all information necessary to complete the determination of eligibility.

**Historical Note**
New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4).

**R9-31-1717. Assignment of Rights**
To be eligible, a parent shall assign rights to any first- or third-party coverage of medical care as specified in Article 10 of this Chapter.

**Historical Note**
New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4).

**R9-31-1718. Approval and Effective Date of Eligibility**
**A.** Approval. An eligibility approval under this Article shall be determined by the Administration. The Administration shall follow the approval notice requirements in R9-31-310(A).
**B.** Effective date of eligibility. The effective date of eligibility is the later of one of the following:
1. The first day of the month following the eligibility determination for a determination made on or before the 25th day of the month,
2. The first day of the second month following the eligibility determination for a determination made after the 25th day of the month, or
3. The first day of the month in which the parent meets all eligibility requirements in this Article.

**Historical Note**
New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4).

**R9-31-1719. Enrollment**
Enrollment for a parent eligible under this Article shall comply with R9-31-1701, R9-31-1702 and R9-31-1703 of this Article. There is no guaranteed enrollment period for a parent eligible under this Article.

**Historical Note**
New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4).

**R9-31-1720. Change and Redetermination**
**A.** Reporting a change. A parent eligible under this Article shall report the following changes to the eligibility agency:
1. An increase or decrease in income,
2. A change of address,
3. A move out of state,
4. An addition or departure of a household member,
5. Any health coverage under private or group health insurance,
6. Eligibility for health coverage under a state health benefit plan based on a family member's employment with a public agency in the State of Arizona,
7 Incarceration of a member,
8. Becoming an inpatient in an IMD, and
9. Receipt of a SSN.

**B.** Verification. If required verification is needed and requested by the eligibility agency as a result of a change specified in subsection (A), to determine the impact on eligibility, and is not received within 10 days, the Administration shall send a notice to discontinue eligibility.

**C.** Redetermination. The eligibility agency shall complete a redetermination of each parent's eligibility at least once every 12 months.

**Historical Note**
New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4).

**R9-31-1721. Denial of Eligibility**

**A.** For a parent of a child under R9-31-1701(C)(1)(a):
1. DES shall deny eligibility under this Article if the parent does not meet a requirement under this Article except for R9-31-1715 of this Article. DES shall follow the denial notice requirements in A.A.C. R9-22-1411(C); and
2. The Administration shall deny eligibility under this Article if the parent does not meet the requirement under R9-31-1715 of this Article. The Administration shall follow the denial notice requirements under R9-31-310(A)(2).

**B.** For a parent of a child under R9-31-1701(C)(1)(b), the Administration shall deny eligibility under this Article if any one of the conditions of eligibility listed in this Article is not met. The Administration shall follow the denial notice requirements under R9-31-310(A)(2).

**Historical Note**
New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4).

**R9-31-1722. Discontinuance of Eligibility**

The Administration shall discontinue eligibility under this Article if any one of the conditions of eligibility listed in this Article is not met. The Administration shall follow the discontinuance notice requirements under R9-31-310(B).

**Historical Note**
New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4).

**R9-31-1723. Newborn Eligibility**

A child born to a mother eligible under R9-31-1701(C)(1)(a) shall follow the newborn eligibility under R9-22-1422. A child born to a mother eligible under R9-31-1701(C)(1)(b) shall follow the newborn eligibility under R9-31-309.

**Historical Note**
New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4).

**R9-31-1724. Grievance and Request for Hearing Process**

**A.** Denial. If DES denies a parent under R9-31-1721 of this Article, the grievance and request for hearing process shall be conducted under A.A.C. R9-22-1433. If the Administration denies a parent under R9-31-1721 of this Article, the request or hearing process shall be conducted under 9 A.A.C. 22, Article 8.

**B.** Discontinuance. If the Administration discontinues a parent under R9-31-1722 of this Article, the grievance and request for hearing process shall be conducted under 9 A.A.C. 22, Article 8.

**C.** Failure to pay premium. If the Administration denies a parent under Section R9-31-1715 of this Article, or discontinues a parent under R9-31-1418, the grievance and request for hearing process shall be conducted under 9 A.A.C. 22, Article 8.

**Historical Note**
New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4).